Waiver Renewal for the Section 1915(b)
Primary Care Case Management (PCCM) Waiver Program

Submitted for review

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PROPOSAL FOR A SECTION 1915(b)
PRIMARY CARE CASE MANAGEMENT (PCCM) WAIVER RENEWAL

Section A. General Impact

I. Background

Managed care in Florida originated in 1984, when Florida was selected as one of five states to receive a grant from HCFA to implement a demonstration program. Between 1984 and 1990 eligible Medicaid recipients were provided with the opportunity to enroll in Medicaid HMOs. However, since Medicaid HMOs were not available statewide, many areas of the State were initially left uncovered. In response, Florida developed a primary care case management (PCCM) program as an alternative strategy to expand managed care throughout the state and to provide Medicaid recipients with another managed care option.

The Medicaid Provider Access System (MediPass) was designed as a managed care alternative for Florida Medicaid recipients. MediPass provides health care services to Medicaid eligibles under a primary care case management model. The goals of MediPass are to:

- assure access to care;
- provide continuity of services;
- strengthen the provider/patient relationship;
- promote educational and preventive aspects of health care;
- reduce unnecessary service utilization; and
- control Medicaid expenditures.

The state submitted the original MediPass waiver application to the Health Care Financing Administration (HCFA) in March 1989; it was approved in January 1990. This application represents the fourth renewal request for the MediPass waiver.

MediPass has evolved into a comprehensive program since its inception. The original MediPass served a relatively healthy population of recipients eligible for aid under Temporary Assistance for Needy Families (TANF). Enrollment into MediPass was expanded to include those recipients receiving SSI (without Medicare) in October 1992. The program became operational throughout the State and enrolled all eligible recipients by June 30, 1996.

In January 1997, a Children's Medical Services Network (CMS Network) for children with special health care needs was developed. The intent was to provide these children with a coordinated system of health care that linked

community based health care with multidisciplinary, regional and tertiary care. These children were assigned to MediPass providers who were also enrolled as part of the Children's Medical Services Network. These providers continued to adhere to all policies established by MediPass and continued to be monitored and evaluated in the same manner as other MediPass providers. Legislation has since mandated the State to operate the CMS Network the center for Medicare and Medicaid Services (formally known as the Health Care Financing Administration, HCFA) under a capitated model. In June 2001, the State received approval from CMS to enter into a contractual relationship with the Department of Health to provide comprehensive health care coverage to children with special health care needs who qualify for coverage under Title XIX of the Social Security Act. The Agency for Health Care Administration will pay the Department of Health a monthly capitation rate for each member who is enrolled in the CMS Network. This new capitated CMS Network will be implemented during this renewal period in phases, in certain geographic areas. The current PCCM CMS Network will remain in effect in those geographic areas where the capitated CMS Network is not implemented. Once all phases are implemented, the CMS Network will be a statewide capitated program.

The Agency received approval from CMS to implement Provider Service Networks on June 19, 1998. The PSN initiative links recipients to a provider network, rather than just a primary care provider, and introduces financial incentives to improve access and health outcomes. Implementation of the first Provider Service Network (PSN) program began March 1, 2000. There is currently one contract for a delivery system in Broward and Miami/Dade counties. The delivery systems and areas are determined through a competitive procurement process.

In June 2001, the State received approval from CMS to implement a program that will enable the provision of additional services to women eligible for Medicaid due to pregnancy (pregnant women who are presumptively eligible or eligible under expanded eligibility requirements of SOBRA). This population has previously been excluded from enrollment in a managed care system due to the limited time these women are enrolled in Medicaid. However, the majority of births paid for by Medicaid are to SOBRA eligible women. Furthermore, the number and percent of births to women eligible under SOBRA is increasing. Therefore, management of their care is critical. This new program will enable the State to manage the care of these women more effectively by expeditiously assisting them in accessing primary care providers and by limiting the panel of primary care providers available to those who provide comprehensive pregnancy related services and who meet requirements to provide optimal prenatal care. In addition, this new program will enable the State to augment Florida's community based system of care by offering expanded services to at-risk pregnant Medicaid eligible women and young children. The overall goal of this new initiative is to

improve birth outcomes and infant health for Medicaid eligibles, thereby ultimately decreasing costs to the Medicaid program.

The State launched a disease management initiative during 1998. The objective of the initiative was to determine if disease-specific care management could decrease Medicaid costs by improving the provision of preventative health care through educating MediPass recipients suffering from a specific disease state, in addition to educating MediPass providers who deliver services to them. Approval was granted by HCFA to pursue limited disease management initiatives in April of 1999. The State received additional approval to expand disease management programs to cover additional disease states in December of 1999. The State contracted with vendors who specialized in managing specific disease states to provide specialized disease specific physician consultants, recipient and provider education, clinical practice guidelines and intensive care management focusing on preventative health care. Telephonic and face-to-face disease management programs were represented to test the effectiveness of both models. The State has implemented programs to address the needs of MediPass recipients living with the following disease states: asthma, diabetes, hemophilia, HIV/AIDS, congestive heart failure, and end stage renal disease.

During this renewal period the State will continue to implement new managed care initiatives in an effort to increase access for recipients while enhancing utilization and provider network controls. Specifically, the State will implement an Exclusive Provider Organization (EPO) in selected geographic regions to provide eligible recipients with an additional managed care option.

This waiver authority has been used to test innovative projects to enhance access and quality of care to enrolled recipients. For example, the State received approval from HCFA on July 24, 2000 to implement a pilot project in Central Florida to test the effectiveness of a telemedicine program. This program was limited to a 6-month intervention period. Enrollment was also limited to a sample of MediPass recipients with Chronic Obstructive Pulmonary Disease (COPD).

The Diabetes Pharmacy Mail Order Program is a specialized service available to MediPass enrollees who have a diagnosis of diabetes and who reside in Medicaid Service Areas 3, 4, 5, and 6. CMS approved this initiative April, 2001. The primary intent of the program is to test the potential for mail order distribution of medications and supplies. Services to be provided by the contractor include provision of products and supplies, drug utilization reviews, 24 hour-a-day, seven day-a-week counseling through a toll-free hotline, and education on both pharmaceutical products and diabetes self-management. Implementation of this new program began November of 2001.

The State has more recently begun to test some new PCCM contracting models to determine if access and quality of care will increase as costs to the Medicaid program decrease.

This waiver authority will also be used to provide selected enrollees, who are diagnosed with specific chronic illnesses, with health literacy interventions. Comprehensive health literacy theories and techniques will be applied to widely accepted health education practices with the goal of enhancing health outcomes. Components of the intervention will include innovative materials and programs for enrollees and for community health center providers and staff, and specific roles and tools for primary care providers, nurses, health care educators, pharmacists, group classes, and one-on-one appointments.

The State has notified the two Tribal Organizations in the State of Florida prior to submitting this waiver renewal request. This notification provided the Tribal Organizations with an opportunity to obtain additional information on Florida's managed care programs or to provide comments regarding the managed care programs.

II. General Description of the Waiver Program

a. **The State of Florida** requests a waiver under the authority of section 1915(b)(1) of the Social Security Act (the Act). Programs included under this waiver authority will be operated directly by the Medicaid agency.

b. **Effective Dates:** Waiver authority is requested for a period of 2 years: effective July 1, 2002 and ending June 30, 2004**.**

c. **Waiver Program Name:** Florida Medicaid Managed Care Programs

d. **State Contact:** The State contact person for this waiver is David Rogers, who can be reached by telephone at (850) 487-2355; by fax at (850) 922-7303; or by e-mail at rogersd@fdhc.state.fl.us.

e. **Automated Data Processing:** Federal approval of this waiver request does not obviate the need for the State to comply with the Federal automated data processing systems approval requirements described in 42 CFR Part 433, Subpart C, 45 CFR Part 95, Subpart F, and Part 11 of the State Medicaid Manual.

f. **Independent Assessment:** The State has arranged for independent assessments of the cost-effectiveness of this waiver and its impact on enrollee access to care of adequate quality.

Independent evaluations of MediPass have been submitted to CMS with past waiver renewal applications. The first evaluation, submitted to HCFA in August 1993, was conducted by the Florida Public Health Information Center at the University of South Florida's College of Public Health. This study evaluated the effectiveness of the original MediPass pilot project implemented in Hillsborough, Pasco, Pinellas and Manatee Counties in October 1991. This initial evaluation found that MediPass improved access to care and continuity of care, while reducing costs of managed services by 25.3 percent. Results from recipient and provider surveys indicated that both MediPass recipients and providers were very satisfied with the program.

The second evaluation, submitted to HCFA in December 1995, was conducted by the Florida State University Policy Sciences Center. The results of this evaluation showed consistent patterns of lower expenditures for services for MediPass enrollees as compared to traditional fee-for-service recipients. Overall, cost savings between MediPass and fee-for-service ranged from 8.5 percent to 19.1 percent. Results from the survey of enrollees and providers showed consistent patterns of satisfaction with the program.

The third evaluation, submitted to HCFA in August 1998, was also conducted by the Florida State University Policy Sciences Centers. Findings from this evaluation were consistent with past evaluations, indicating substantial savings when MediPass costs were compared to fee-for-service for services provided to AFDC and SSI-No Medicare enrollees. In addition, MediPass enrollees and providers continued to voice satisfaction with the program.

This application represents the fourth renewal request for the MediPass waiver. Studies were completed to evaluate new program components included under MediPass, in addition to an independent evaluation to examine the MediPass program overall. Independent evaluations have been submitted to CMS. The following program components, which became operational during the last waiver period, were evaluated through independent evaluation(s):

- The Provider Service Network
- The Asthma Disease Management Program
- The Diabetes Disease Management Program
- The Hemophilia Disease Management Program
- The AIDS Disease Management Program

g. Statutory Authority: The State's waiver authority is authorized under Section 1915(b)(1) of the Act, which provides for a primary care case

management (PCCM) system or specialty physician services arrangement under which the State restricts the provider from or through whom a beneficiary can obtain medical care.

The State is also relying upon authority provided in the following section(s) of the Act:

1915(b)(2): The State has an independent enrollment broker to assist eligible individuals in choosing among managed care options in order to provide recipients with more information about the range of health care options open to them.

Healthy Start Coalitions, locally based entities authorized by Florida Statute, are responsible for assisting women who are presumptively eligible for Medicaid or eligible under expanded eligibility categories due to pregnancy with selecting a Medicaid primary care provider to coordinate their medical care.

See Waiver Section A.III.b (Enrollment/Disenrollment).

1915(b)(3): The State will share cost savings resulting from the use of more cost effective medical care with recipients by providing them with additional services.

Disease management services will be provided to eligible recipients enrolled in the MediPass PCCM option to improve medical self-management through the provision of preventative care management and educational activities.

Health literacy interventions will be provided to select MediPass enrollees who have a diagnosis of a specific chronic illness.

The Frail/Elderly Program is an expanded service provided by the Medicaid HMOs to provide, coordinate and manage services for the frail and elderly who need such services to prevent or delay placement in a nursing home.

Savings will be shared through the provision of additional services to at risk Medicaid eligible pregnant women and young children (0 to 36 months). Additional care coordination and access to other Healthy Start services will reduce the factors and situations that place pregnant women and young children at jeopardy for poor health outcomes.

Additional services to be provided under the waiver, which are not covered under the State plan, are listed in Section A.III.d.

1915(b)(4): This waiver authority limits who is eligible to provide services to enrolled recipients. The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services.

MediPass enrolled recipients who have a diagnosis of diabetes and who reside in Medicaid Service Areas 3, 4, 5, or 6 are required to obtain prescriptions from a contractor selected by the State.

Locally based Healthy Start Coalitions are currently responsible for providing care coordination and case management services to pregnant women and young children. These entities, established under the authority of Section 383.216, Florida Statutes, operate under the direct oversight of Florida's Title V grantee (the Florida Department of Health). A competitive procurement process for Coalitions will begin July 2003, with contract awards scheduled to be implemented in July 2004.

The State uses a competitive bidding process to select Provider Service Networks. Provider Service Networks must serve at least one entire county, and contracts will not be awarded where PSN service areas would overlap with one another. PSN enrollees must obtain the majority of services from PSN Network providers.

The State will use a competitive bidding process to select Exclusive Provider Organizations (EPOs). EPO enrollees will be required to obtain the majority of services from providers within the EPO.

See Section A.III.c, and access standards described in Section B. Provider criteria standards are described in Section C.

Other Statutes: The State is relying on the authority provided in Section 1915(a) of the Act. For the CMS Network, the State will enter into a contract with The Florida Department of Health, Children's Medical Services (CMS) to provide care and services in addition to those offered under the State Plan to individuals eligible for medical assistance who reside in the geographic area served by the CMS Network and who voluntarily elect to obtain such care and services from the CMS Network. Implementation of this new capitated CMS Network will occur in phases based on geographic area. The existing CMS Network, operating as a component of MediPass, will continue to serve recipients until the new capitated CMS Network is available.

h. Sections Waived. Relying upon the authority of the above Section(s), the State requests a waiver of the following Sections of 1902 of the Act:

Section 1902(a)(1): All program components of this waiver authority will not be available throughout the State.

Section 1902(a)(10)(B): Program components of this waiver authority include additional benefits such as case management and health education that will not be available to other Medicaid recipients not enrolled in a program under this waiver authority.

Section 1902(a)(23): Under this waiver authority, free choice of providers is restricted.

Currently, there is one PCCM system, with a choice of two or more primary care providers, available to recipients in all counties. In most counties, there is also a choice of at least one HMO in addition to MediPass. In Miami/Dade and Broward counties, there is a choice of MediPass, the Provider Service Network, and HMOs. The EPO will be available to eligible recipients in Medicaid Service Areas 1 through 4, in counties where HMOs are currently not available.

i. Geographical Areas included under this Waiver Authority:

Under this waiver authority, Medicaid managed care programs are available Statewide. The following chart details the service areas in which Medicaid managed care programs operate throughout Florida.

Medicaid Area / Counties / Major City in Area
Medicaid Area 1: Counties include Escambia, Okaloosa, Santa Rosa, and Walton (Pensacola)
Medicaid Area 2: Counties include Bay, Franklin, Gulf, Holmes, Jackson, Washington, Calhoun, Gadsden, Jefferson, Leon, Liberty, Madison, Taylor, and Wakulla (Tallahassee and Panama City)
Medicaid Area 3: Counties include Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, Union, Citrus, Hernando, Lake, Marion, and Sumter (Gainesville and Ocala)
Medicaid Area 4: Counties include Baker, Clay, Duval, Nassau, St. Johns, Flagler, and Volusia (Jacksonville and Daytona Beach)
Medicaid Area 5: Counties include Pasco and Pinellas (St. Petersburg)
Medicaid Area 6: Counties include Hardee, Highlands, Hillsborough, Manatee, and Polk (Tampa)
Medicaid Area 7: Counties include Brevard, Orange, Osceola, and Seminole (Orlando)
Medicaid Area 8: Counties include Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota (Ft. Myers)
Medicaid Area 9: Counties include Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie (West Palm Beach)
Medicaid Area 10: Broward County (Ft. Lauderdale)
Medicaid Area 11: Miami/Dade and Monroe Counties (Miami and Florida Keys)

Currently, the State's PCCM program, MediPass, is available in all Medicaid Service Areas. Some components of the waiver authority extended to MediPass recipients may not be available on a statewide basis. For example, the Diabetes Pharmacy Mail Order Program is currently available to provide services to MediPass recipients who reside in Medicaid Service Areas 3, 4, 5, and 6.

The current CMS Network, which operates as a component of the existing MediPass PCCM program, is available in all Medicaid Services Areas. The new capitated CMS Network will occur during this renewal period in phases, based on geographic area. Initial implementation of the capitated

network is anticipated to be phased in for Medicaid Service Areas 3, 4, 5, 6, and 11. The current PCCM CMS Network will remain in effect in those geographic areas where the capitated CMS Network is not implemented. Once all phases are implemented, the CMS Network will be a statewide capitated program.

The Healthy Start Coordinated Care System for Pregnant Women and Infants is available statewide.

Currently, the Provider Service Network is available in Miami-Dade and Broward counties.

HMOs are currently available in the following Medicaid Areas:

Medicaid Area / Counties with available HMO(s)
Medicaid Area 1: Counties include Escambia and Santa Rosa
Medicaid Area 2: Counties include Gadsden, Jefferson, Leon, Liberty, Madison, and Wakulla
Medicaid Area 3: Counties include Alachua, Citrus, Dixie, Gilchrist, Hernando, Lake, Levy, Marion, Putnam, and Union
Medicaid Area 4: Counties include Baker, Clay, Duval, Nassau, and Volusia
Medicaid Area 5: Counties include Pasco and Pinellas
Medicaid Area 6: Counties include Highlands, Hillsborough, Manatee, and Polk
Medicaid Area 7: Counties include Brevard, Orange, Osceola, and Seminole (Orlando)
Medicaid Area 8: Counties include Hendry, Lee, and Sarasota
Medicaid Area 9: Counties include Martin, Palm Beach, and St. Lucie
Medicaid Area 10: Broward County
Medicaid Area 11: Miami/Dade County

An EPO will be available as an additional managed care option in Medicaid Service Areas 1 through 4, in counties where there is currently no HMO.

J. Waiver Population: The following populations may be enrolled in a managed care program included under this waiver authority:

- Low income families and children (TANF)
- Supplemental Security Income (SSI) beneficiaries
- Sixth Omnibus Budget Reconciliation Act (SOBRA) recipients/ children
- Pregnant women who are presumptively eligible or eligible under expanded eligibility requirements of SOBRA will be enrolled in the Healthy Start Coordinated Care System for Pregnant Women and Infants component of this waiver. Florida grants eligibility up to 185 percent of poverty. Receipt of wrap around services is optional. Service receipt is optional for eligible children up to thirty-six months who are eligible under expanded eligibility categories.
- Children with special needs due to physical and/ or mental illnesses and/or developmental disabilities
- Children in foster care or subsidized adoption arrangements

Exceptions to the included populations provided above include:

- Medicaid eligible recipients who, at the time of application for enrollment and/or at the time of enrollment, are domiciled or residing in an institution, including nursing facilities, intermediate care facilities for persons with developmental disabilities, state hospitals or correctional institutions.
- Medicaid eligible recipients who are eligible as medically needy.
- Medicaid eligible recipients who have an eligibility period that is only retroactive.
- Medicaid eligible recipients who are receiving services through a hospice program.
- Medicaid eligible recipients who are also members of a Medicare-funded health maintenance organization.
- Qualified Medicare beneficiaries (QMBs).

- Medicaid eligible recipients who have other major medical insurance like CHAMPUS or a private HMO.

- Medicaid eligible recipients who reside in the following:
  - ✓ Residential commitment programs/facilities operated through the Department of Juvenile Justice;
  - ✓ Residential group care operated by the Family Safety and Preservation Program in the Department of Children and Families (DCF);
  - ✓ Children's residential treatment facilities purchased through the Alcohol, Drug Abuse, and Mental Health Program Office (ADM) in DCF (Purchased Residential Treatment Services – PRTS);
  - ✓ ADM residential treatment facilities licensed as Level II facilities; and
  - ✓ Residential Level I and Level II substance abuse treatment programs pursuant to section 10E-16.009(2) and (3), F.A.C.

- Family Planning waiver recipients

- Medicaid eligible recipients who are members of the Channeling program or an aged and disabled waiver program may not enroll in a Medicaid HMO with a frail/elderly component.

III. PROGRAM IMPACT:

The following informational sections contain required information which describes programs included under this waiver authority.

a. Marketing:

The State does not permit direct or indirect marketing by primary care providers. Federal and State marketing requirements are included in contractual agreements with PSNs, HMOs and EPOs. Marketing activities conducted by these entities must comply with contractual requirements.

b. Enrollment/Disenrollment:

Enrollment Broker Activities

Enrollment in a managed care option is mandatory for covered populations. Counseling is available to all potential enrollees regarding their choices prior to the selection of their plan.

The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care programs available.

The State contracts with an independent contractor (i.e., enrollment broker) to conduct the enrollment process. The State undertook a competitive procurement process to contract with an enrollment broker. The contracted enrollment broker is responsible for disseminating informational materials to assist in the selection of a managed care option. The enrollment broker is also responsible for the operation of a call center to provide additional guidance to managed care enrollees and potential enrollees, and to accept voluntary enrollment and enrollment change requests from recipients or their representatives.

Potential enrollees receive information packets by direct mail. The packets are designed to guide recipients through the decision making process by providing comparative information on plan choices available. Each eligible recipient is provided with information on how to select a health care provider and basic information on how MediPass, the Children's Medical Services Network, the Health Maintenance Organizations (HMOs), the Provider Service Network (PSN), and the Exclusive Provider Organizations (EPOs) operate.

The enrollment broker operates a call center where choice counselors are available to answer recipients' questions about available plans, PCP availability and other network information. Enrollees may notify the enrollment broker of their choice of plan by phone. If the recipient selects enrollment in the CMS Network, the enrollment is completed by mail, telephone, or in person by the local Medicaid office rather than the enrollment broker.

Choice counselors are provided with training and general information to enable them to assist special populations and persons with special health care needs choose the appropriate managed care option. All potential enrollees are provided with information about available disease management programs. Screening questions are asked during the phone call to determine if potential enrollee is a child with special health care needs. If special health care needs are identified or suspected for a child, necessary information to contact Children's Medical Services for further information and medical eligibility screening is provided. Once medical eligibility is determined by Children's Medical Services, assistance with primary care provider selection is provided by CMS staff.

Because it is important that pregnant women receive care as soon as possible, the method for enrolling pregnant women who are presumptively eligible due to pregnancy and expanded income requirements as specified

under SOBRA differs from procedures for enrolling other eligibility groups as described above. Healthy Start Coalitions will be responsible for providing choice counseling to SOBRA women in selecting their primary care provider from a panel of Medicaid enrolled providers who agree to meet specified standards of care. The Healthy Start Coalitions are locally based entities authorized by Florida Statute in 1991. A competitive procurement process will be repeated three years after the waiver has been in effect. This procurement for Coalitions will begin July 2003, with contract awards scheduled to be implemented in July 2004.

The Department of Children and Families (DCF) determines eligibility for this population as presumptively eligible or eligible under SOBRA. DCF uses a simplified eligibility form for this process. This simplified form helps ensure 1) earlier access to prenatal care; 2) enrollment of more eligible women with fewer cases of uncompensated care; and 3) greater continuity of care. Prior to use of this modified form, care was disrupted when presumptively eligible women failed to follow through in a timely manner with a full application. Once eligibility is determined, DCF enters eligibility and anticipated delivery date into the client information system and Florida's Medicaid fiscal agent is notified. Medicaid's fiscal agent then sends all presumptively eligible and newly enrolled SOBRA pregnant women the following:

- Notice that they have to choose a provider to manage their care while pregnant. The notice includes the name and telephone number of the Healthy Start Coalition that will be responsible for counseling them.

- A pamphlet explaining the program and their options.

Concurrently, the fiscal agent notifies the relevant Healthy Start Coalition of the new enrollment. The Healthy Start Coalition is responsible for attempting to contact each woman within five working days to:

- Explain the program including program benefits, how to access both primary care and wraparound services, register grievances and answer questions;

- Provide a list of provider choices for primary care services while they are pregnant;

- Assist recipients to their choice of a medical provider;

- Register the recipient's choice;

- Facilitate the initial or next appointment with the selected provider;

- Arrange or provide for a Healthy Start screen if not already completed; and

- Determine if the recipient is enrolled in the Women Infant and Children's (WIC) nutrition program and if not participating facilitate enrollment.

The goal of Healthy Start is to enroll recipients within 30 days of eligibility with the selected PCP, and have the Healthy Start screen completed. If the enrollee does not make a choice of provider within 30 days, the enrollee is assigned to a provider who is within a 30-minute drive of the enrollee's residence. If there are no providers within a thirty-minute drive, assignment will be to the provider who is the closest to the recipient's residence.

Mandatory Enrollments

Enrollment in either MediPass, the Provider Service Network, an EPO, or an HMO is mandatory for covered populations. Enrollment in the Healthy Start Coordinated Care System is mandatory for women who are determined presumptively eligible or eligible for Medicaid due to pregnancy. Receipt of wrap-around services is voluntary for all other eligible women who will continue to receive services as provided by the managed care program they select.

The State allows otherwise mandated recipients to request exemption from enrollment in managed care by contacting the enrollment broker and/or the local Medicaid office. Each request is reviewed on a case-by-case basis.

If a managed care eligible recipient does not voluntarily select a plan within the given timeframe, the recipient will be auto-assigned, as appropriate, to a PCCM (MediPass) provider, a Provider Service Network provider, an HMO, the Healthy Start Coordinated Care System, or an EPO. Certain PCCM providers, such as the minority physician networks and the pediatric ER diversion projects, are treated as separate managed care plans (separate from MediPass) for the purpose of the mandatory assignment process. The beneficiary will not be auto-assigned or default-assigned to the CMS Network. Recipients are auto assigned to managed care options based on their program eligibility code and county residence. For example, if the recipient is eligible for enrollment into MediPass, the PSN, or an HMO, then the assignment is made based on a predefined

rotation among the available options. In some instances, the recipient will only be eligible for mandatory enrollment into MediPass (i.e., foster care children) or into the Healthy Start Coordinated Care System (i.e., SOBRA Pregnant Women).

If the managed care eligible recipient was previously enrolled in MediPass, an HMO, the PSN, an EPO, or in the CMS Network (within a one-year time period), he or she will be auto-assigned to his or her previous plan selection in addition to his or her previous provider (within the plan). This is the only time a recipient would be auto-assigned into the CMS Network.

Enrollment in the CMS Network is voluntary. However, if the recipient does not choose to enroll in the CMS Network, he or she must choose another managed care option and will not be eligible to receive services from CMS.

Children placed in foster care or subsidized adoption arrangements are eligible for Medicaid managed care enrollment. If the child is already enrolled in MediPass, the client may remain with the current provider or change providers at the joint wish of their Children and Families worker and foster parents. Foster children and subsidized adoption children not already enrolled in a managed care program will be mandatorily enrolled in the State's PCCM program, MediPass, unless the DCF worker enrolls the child in an HMO.

When recipients assigned to MediPass fail to choose their own PCP, they are auto-assigned to a PCP who resides sufficiently near their residence. Mandatory assignments of MediPass recipients are computer generated. The assignment criteria utilized takes into consideration the recipient's residence and grouping of children, age, sex and provider type.

Recipients who are enrolled in MediPass and who suffer from a chronic illness for which there is a disease management program available will be automatically identified for enrollment in the appropriate disease management program. Each eligible recipient (or their legal guardian) will be contacted by mail and advised of their enrollment into a disease management program as well as the benefits of participating in the program. Recipients will not be contacted by the DMO until after the completion of an initial enrollment period (generally thirty days). This enrollment period will provide the recipient with a period of time to respond to the Agency and opt-out of the program if they do not wish to participate in the disease management program. The recipient may also choose to disenroll from the disease management program at any time by contacting the Agency.

Recipients who are enrolled in MediPass, who reside in Medicaid Areas 3, 4, 5, or 6, and who have a diagnosis of diabetes will participate in the Diabetes Pharmacy Mail Order Program. Participation in this program is mandatory for all eligible MediPass recipients who reside in Medicaid Areas 3, 4, 5, or 6.

Lock-In

The State uses a default enrollment process and a lock-in period of 12 months. Unless ineligible for managed care enrollment, newly eligible recipients will receive initial notification of the requirement to enroll in a managed care plan. This initial notification includes informational materials about the available managed care options and a letter which specifies the amount of time available to make a choice. This letter also provides a telephone number that the potential enrollee may call to receive telephone counseling services.

Enrollees are permitted to change managed care programs without cause within the first 90 days of the enrollment period with the selected or assigned managed care option; (i.e., HMO to MediPass or PSN or MediPass/PSN to an HMO, or from one HMO to another, etc.) At the end of the 90 days they are locked in to that program or plan for 12 months. Lock-in only applies to the managed care option. Recipients may change primary providers within the assigned/chosen managed care option at any time. In addition, participation in the CMS Network is voluntary and enrollees are exempt from the lock-in requirement.

There is a 60-day annual open enrollment period. Enrollees will be notified of their ability to change managed care options at the end of their enrollment period at least 60 days before the end of that period. Enrollees shall be permitted to change managed care options for good cause during the lock-in period. Recipients may disenroll from the CMS Network and choose another managed care option at any time. Others exempt from lock-in may also change managed care options at any time.

The following specific populations are exempt from the lock-in requirement:

(1) Dual Medicare-Medicaid eligibles;

(2) Indians who are members of federally-recognized tribes; and

(3) Children (under age 19) who are;
(a) eligible for SSI under

Title XIX;
(b) described in section 1902(e)(3) of the Social Security Act;
(c) in foster care or other out-of-home placement;
(d) receiving foster care or adoption assistance; or
(e) receiving services through a family-centered, community-based, coordinated care system receiving grant funds under section 501(a)(1)(D) of Title V.

The process for Healthy Start Coordinated Care System enrollees differs from that described above. Enrollees in this program can change PCPs by notifying the Healthy Start Coalition within 60 days from being determined eligible for the program. After 60 days they will be locked into the PCP selected or assigned with the following exceptions:

- Change of county of residence;
- Cause, such as inability to schedule appointments in a timely manner with the provider, or provider/patient conflict;
- Provider termination from Medicaid or relocation;
- Recommendation of provider based on complications of pregnancy (for example, to a Regional Perinatal Intensive Care Center [RPICC] provider); and
- Assignment was made by Healthy Start. In which case, the enrollee will have 60 days from date notified of assignment by Healthy Start to change providers.

If a Healthy Start Coordinated Care System enrollee changes eligibility groups, the recipient will have the option of selecting a managed care provider (through MediPass, an HMO, an EPO, or the PSN) in accordance with the rules and regulations applicable to selecting a managed care provider for that eligibility group. The Healthy Start Coalition will assist recipients in ensuring their prenatal care is not interrupted throughout this process.

Disenrollments

Enrollees who are exempt from lock-in, and CMS Network enrollees, may disenroll from the assigned managed care plan and choose another managed care option at any time. Other enrollees are not permitted to change managed care options outside of open enrollment periods, except

for good cause. The State is responsible for processing all disenrollments.

The Provider Service Network, HMOs, and EPO must submit recipient involuntary disenrollments to the agency. These managed care plans are contractually required to maintain documentation on all disenrollment requests, including reasons for involuntary disenrollments.

The CMS Network recipient's eligibility is redetermined annually. A recipient may be disenrolled from the CMS Network if no longer financially or medically eligible. If the child is no longer eligible, the child will be disenrolled from the CMS Network effective the last day of the month following the eligibility determination process. The CMS Network will assist the family with transition to other age-appropriate coverage options. Currently, the CMS area office submits a disenrollment form to the area Medicaid office.

All managed care enrollees may disenroll/transfer between primary care providers within the same managed care option without cause and at any time. All enrollment changes or exemptions made before the middle of the month will take effect the first of the following month.

All voluntary transactions are tracked by the State. However, since enrollees who are not locked in do not have to give a reason to change providers this information may not be comprehensive. The enrollment broker is contractually required to ask and accurately record the plan change/disenrollment reason for all recipients who request such a change. However, the recipient is not required to be specific in non-lock-in situations, nor is the reason for change verified unless the recipient is locked in and is requesting a good cause change.

The State arranges for Medicaid services to be provided without delay to any enrollee of a MediPass or Healthy Start primary care provider whose contract is terminated and any enrollee who is disenrolled by a primary care provider for any reason other than Medicaid ineligibility. Continuity of care arrangements are contractually required from other managed care plans.

The State has mechanisms in place to ensure continuity of care when a recipient is transitioned from fee-for-service to PCCM, or from one primary care provider to another as a result of involuntary disenrollment. The State reviews and approves all primary care provider-initiated requests for enrollee transfers or disenrollments of MediPass and Healthy Start enrollees. Patients may be disenrolled only if the provider/patient relationship is not satisfactory or if the primary care provider feels a

specialist can better serve the recipient's medical needs. If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the primary care provider to remove the enrollee from the primary care provider's caseload. The enrollee remains an enrollee of the primary care provider until another primary care provider is chosen or assigned. Although a MediPass PCP may request that a recipient be removed from his caseload, he or she must continue to render services to the enrollee while the disenrollment is being completed.

c. Entity Type or Specific Waiver Requirements:

The State believes that the requirements of section 1915(b)(4) of the Act are met for the following reasons:

- Although the organization of the service delivery and payment mechanism for that service are different from the current system, the standards for access and quality of services are the same or more rigorous than those in the State's Medicaid State Plan.

- The contractor must provide or arrange to provide for the full range of Medicaid services to be provided under the 1915(b)(4) waiver.

- The contractor must agree to accept as payment the reimbursement rate set by the State as payment in full.

- Enrollees residing at a long term care facility are not enrolled in these managed care programs.

- There are no restrictions that discriminate among classes of providers on grounds unrelated to their demonstrated effectiveness and efficiency in providing services.

The State uses an open cooperative procurement process in which any qualifying primary care case management entity may participate who complies with procurement requirements and 45 CFR Section 74.

Provider Qualifications

The following types of providers qualify to be Primary Care Providers under Florida's PCCM program (MediPass):

- Physicians
  - ✓ Pediatricians
  - ✓ Family Practioners

- ✓ Internists
- ✓ General Practitioners
- ✓ Obstetricians/Gynecologists

- Federally Qualified Health Centers

- Rural Health Centers

- Advanced Registered Nurse Practitioners (including licensed nurse midwives)

- Physician Assistants

- Other specialists as appropriate

MediPass Primary Care Providers (PCPs) must be Medicaid enrolled providers and agree to comply with all applicable federal statutory and regulatory requirements, including those in Section 1932 of the Act and 42 CFR 434 and all State Plan standards regarding access to care and quality of service. MediPass providers who accept CMS Network recipients must meet MediPass provider qualifications in addition to CMS consultant physician criteria (as determined by the Department of Health, Children's Medical Services (CMS) Program Office).

All primary care providers who enroll in MediPass are credentialed by the Agency. All enrolled MediPass providers are also re-credentialed by the Agency on a routine basis. Providers are responsible for submitting a credentialing package to the Agency that includes the Agreement for Participation in MediPass and the MediPass Provider Enrollment Form. Local Medicaid staff perform a credentialing site visit following the receipt of the completed credentialing package. Provider applications are verified and processed by Medicaid Headquarters' staff upon receipt of a completed credentialing package and site survey. Each provider's final credentialing package is presented to the MediPass Credentialing Committee for approval. The MediPass Credentialing Committee consists of five members: two physicians, two nurses, and the MediPass Program Administrator or his designee. All committee members are appointed and reappointed every two years by the Chief of Medicaid Program Development. In order to approve a MediPass provider, a majority of the Credentialing Committee members present must vote for approval.

The Department of Health, Children's Medical Services (CMS) Program Office, will be responsible for administering and managing all aspects of the capitated CMS Network in order to provide comprehensive health care coverage to children with special health care needs who qualify for

coverage under Title XIX of the Social Security Act. Under Florida law, CMS has responsibility for administering services under Title V of the Social Security Act. CMS Network providers who will participate in the capitated network must be eligible for participation in the Medicaid program. All subcontracted providers must sign subcontracts that meet the standards set forth in the CMS Network contract. CMS Network providers must also meet the additional CMS consultant physician criteria as determined by the Department of Health, Children's Medical Services (CMS) Program Office.

Providers who may serve recipients enrolled in the Healthy Start Coordinated Care System for Pregnant Women and Infants are not required to be MediPass PCPs. Healthy Start providers are selected from those enrolled in the Medicaid program who agree to meet the Department of Health's standards for optimal prenatal care. Healthy Start providers are enrolled in the program by the Agency based on their demonstrated capacity and their agreement to meet prenatal care standards.

All Provider Service Network (PSN) primary care providers must be Medicaid providers and also meet all MediPass provider requirements. The PSN is contractually responsible for credentialing and recredentialing its provider network.

HMOs and EPOs must ensure that all providers of service are eligible for participation in the Medicaid program. All subcontracted providers must sign subcontracts that meet the standards set forth in the Medicaid HMO or EPO contract. In addition, each plan must fully credential each provider in accordance with standards set forth in the Medicaid HMO or EPO contract. These standards are consistent with those required by national accreditation organizations.

Provider Responsibilities

MediPass PCCM entities sign a contract for enrollment as a MediPass primary care provider. This contract explains the primary care providers' responsibilities and complies with the PCCM contract requirements in Section 1905(t)(3) of the Act including: make available 24-hour, 7 days per week access by telephone to a live voice (an employee of the primary care provider or an answering service) or an answering machine which will immediately page an on-call medical professional for information, referral, and treatment of medical emergencies; referrals for non-emergency services; or to information about accessing services or how to handle medical problems during non-office hours.

HMO, PSN, CMS Capitated Network, and EPO providers are contractually required to provide enrollees with access to health care services on a 24-hour, seven-day-a-week basis.

Primary care providers are also responsible for the following:

- providing comprehensive primary health care services to all eligible Medicaid recipients who choose or are assigned to the primary care provider's practice;

- referring or making arrangements for sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care;

- maintaining a unified medical record for each enrollee by documenting in one record all the services and treatments provided, laboratory test results, prescribed medications, all referrals and authorizations, and reports from providers;

- having hours of operations that are reasonable and adequate;

- not refusing an assignment or disenrolling an enrollee or otherwise discriminating against an enrollee solely on the basis of age, sex, race, physical or mental handicap, national origin, or health status or need for health services, except when that illness or condition can be better treated by another provider type;

- taking recipients in the order in which they enroll with the primary care provider;

- not having an affiliation with person debarred, suspended, or otherwise excluded from federal procurement activities per Section 1932(d)(1) of the Act.

Disease management service providers are required to use care managers with experience and training in treatment of the specific disease state to coordinate services across the full continuum of care. Disease management care managers must coordinate their patient management activities with the MediPass PCP and specialists.

Providers who serve recipients enrolled in the Healthy Start Coordinated Care System for Pregnant Women and Infants are responsible for providing the following services to all enrollees:

- Complete the Healthy Start screen in a timely manner and otherwise cooperate with the provision of wraparound services and WIC, if indicated;

- Screen for substance abuse including alcohol abuse;

- Screen for HIV status and if infected treat or refer the patient to a specialist to treat in accordance with recommended practice protocols promulgated by the Department of Health;

- Complete a recommended panel of tests including those for infections (STDs);

- Provide access to genetic counseling through the Department of Health/Children's Medical Services program;

- Recommend zinc and folic acid supplements in accordance with recent research;

- Adhere to practice guidelines for Caesarian deliveries;

- Transfer high risk women to RPICC providers in a timely manner when referral criteria are met; and

- Meet other criteria to be developed by the Department of Health in conjunction with the Agency and providers representing evidence-based medical care in order to decrease variability of outcome, utilization, and cost.

Healthy Start providers with historically poor performance on the above criteria may be excluded from the panel.

The assigned MediPass PCP is responsible for making referrals to Medicaid enrolled providers for specialty care by providing an authorization number to the specialty provider (required in order for the specialty provider to be paid for services). Patients may also be referred to non-Medicaid providers who will donate their services and not bill the patients. The PCP is responsible for obtaining reports of treatment and follow-up from the specialists and other referral physicians who treated their patients.

All Medicaid covered services are prior authorized by the assigned PCP under MediPass and the Healthy Start Coordinated Care System with the exception of the following services:

- Dental
- Mental Health Services
- Visual Services
- Hearing Services
- Freestanding Dialysis Centers
- Independent Laboratories
- General Transportation and Ambulance/Wheelchair Van
- Chiropractic (up to 10 visits annually; after that must be prior authorized)
- Podiatry (up to 4 visits annually; after that must be prior authorized)
- Nursing Home and ICF/DD
- Family Planning
- Emergency Services
- Healthy Start Wraparound Services

No MediPass provider can be forced to give authorization for specialty care. Some providers resist giving authorization for medical treatment for a variety of reasons which often include:

- They have never seen the recipient;
- They are not aware of a recipient's pre-existing medical condition;
- They do not approve of the treatment for the particular recipient; or
- They are available themselves to treat their recipients.

The treating provider may contact the area Medicaid office for review of these cases. Authorization may be granted by the area office and the claim treated as a force pay in situations wherein treatment had already been provided. Each situation is treated separately on a case-by-case basis. All involved parties may participate in the process (recipient, treating provider, and MediPass provider).

Care coordination for recipients enrolled in the PSN, an HMO, or an EPO is specifically defined for each plan in the Medicaid PSN, HMO or EPO contract. Each plan is responsible for developing and maintaining policies and procedures for referrals.

PCP prior authorization is not required for specific services provided by "public providers". However, post authorization is required to ensure that the PCP is aware of services rendered. This provision is limited to services provided for the following:

- The diagnosis and treatment of sexually transmitted diseases and other communicable diseases such as tuberculosis and HIV.
- The provision of immunizations.
- School health services.
- Services rendered on an urgent basis.
- The provision of emergency shelter medical screenings at County Health Departments for recipients of the Department of Children and Families.

In accordance with regulations, preauthorization of emergency and family planning services by the PCP is not required under any managed care option. Enrollees may obtain these services from any Medicaid provider.

All services provided to MediPass, CMS, Healthy Start, and PSN enrollees are tracked by the fiscal agent and monitored as fee for service expenditures. Healthy Start wraparound services are tracked and monitored by the Healthy Start Coalitions. In addition, Healthy Start services provided are entered into the Department of Health (DOH) Management Information System.

Each HMO is responsible for complying with all reporting requirements as specified in the Medicaid HMO contract. Required reports include quarterly service utilization reports.

The EPO will be responsible for complying with all reporting requirements as specified in the Medicaid EPO contract.

Reimbursement

MediPass Primary Care Providers and providers who are enrolled under the current CMS Network are reimbursed on a fee-for-service basis. These PCPs currently receive a monthly case management fee of $3.00 per enrolled MediPass or CMS Network recipient. Providers who deliver specialty care to MediPass enrollees are reimbursed on a fee-for-service basis.

Providers serving the population enrolled in the Healthy Start Coordinated Care System for Pregnant Women and Infants are reimbursed on a fee-for-service basis. The Healthy Start Coalitions will receive a monthly fee of $12.00 for each SOBRA recipient enrolled in this program. This fee is for care coordination, case management and choice counseling.

The capitated CMS Network contract will include an assumption of full risk (at 100% of fee-for-service expenditures) by the Department of Health, Children's Medical Services with risk corridors set by the Agency. The capitation amount paid to the CMS Network will be determined based on historical per capita Medicaid expenditure data for services and indirect costs for CMS children with special health care needs. Costs will be defined as payment for services, plus administrative expenses associated with medical management, claims payment, reporting, quality assurance, network development and related administrative expenses. Based on the monthly enrollment of CMS Network children assigned, the CMS Network will receive the appropriate monthly capitation rate for each member. CMS Network children and their families will be held harmless for the costs of all covered services provided. There will be no co-payments or deductibles. The CMS Network is responsible for paying all in-network and out-of-network provider claims for authorized or emergency services rendered to members under this contract. The CMS Network will assure access to care under this rate structure. The Department of Health, Children's Medical Services is a state agency and the full faith and credit of the state ensures that costs exceeding the upper payment limit within the risk corridor will be assumed by the CSM Network. Additional solvency requirements will be outlined in greater detail within the CMS Network contract.

The Provider Service Network is structured as a fee-for-service model. The PSN is paid a monthly administrative allocation that is a percentage of an upper payment limit. Primary care providers receive three-dollars per

member per month in addition to FFS reimbursement. Providers who deliver specialty care to PSN enrollees are reimbursed on a fee-for-service basis. The PSN has the potential of receiving a percentage of total funds available for shared savings. Specific information on the availability of funds for shared savings is provided in the approved PSN contract.

HMO and EPO contractors are paid a fixed monthly capitation rate per member in each of the various eligibility categories, by age group, to provide all covered services required by each member during the month. The capitation rate is a percentage of the actual fee-for-service Medicaid claims experience for each eligibility category in the plan's operating area.

d. Services

The MediPass and Healthy Start Coordinated Care System PCP is required to maintain a unified medical record for each enrollee by documenting in one record, at a minimum, medical charts, prescription files, and other services and treatments provided to disclose the quality, quantity, appropriateness, medical necessity and timeliness of services performed, referred or authorized. All aspects of patient care, including ancillary services, tests, therapies and prescribed regimens, follow up, referrals and results from referrals must be maintained by the PCP.

In addition to emergency care and family planning, MediPass and Healthy Start Coordinated Care System enrollees may access certain services without prior authorization. Enrollees may obtain such services from a Medicaid provider of their choice without authorization. In addition, Mental Health Related Services are also not managed except in Hillsborough, Manatee, Hardee, Highlands, Polk, Escambia, Okaloosa, Santa Rosa, and Walton counties. All recipients residing in these counties must obtain their mental health services through a Prepaid Mental Health Plan.

The following charts provide program-specific summaries of provider responsibilities for delivering, prescribing, or referring to Medicaid services. A chart is provided for each type of managed care delivery system described in this document.

MediPass and the Healthy Start Coordinated Care System – Summary of Services					
Service	State Plan Approved	1915(b)(3) Waiver Services	Referral/ Prior Authorization Required	Referral/Prior Authorization Not Required or Non-Waiver Services	Wraparound Service – effected by PCCM
Child Health Check-Up	X		X		
Chiropractic	X			X (up to 10 visits per year)	
Dental	X			X	
Dermatology	X		X		
Dialysis	X			X	
Disease Management		X			
Durable Medical Equipment	X		X		
Emergency Services	X			X	
Family Planning	X			X	
FQHC Services	X		X		
Health Literacy Interventions		X			
Healthy Start Services		X			
Hearing	X			X	
Home Health Services	X		X		
Immunizations	X		X	X (from public providers only – post authorization required)	

MediPass and the Healthy Start Coordinated Care System – Summary of Services					
Service	State Plan Approved	1915(b)(3) Waiver Services	Referral/ Prior Authorization Required	Referral/Prior Authorization Not Required or Non-Waiver Services	Wraparound Service – effected by PCCM
Inpatient Hospital	X		X		
Lab	X			X	
Mental Health	X			X	
Nursing Home / ICF	X			X	
Outpatient Hospital	X		X		
Personal Care	X		X		
Physical / Speech Therapy	X		X		
Physician	X		X		
Podiatry	X			X (up to 4 visits per year)	
Prescribed Drugs	X		X		
Private Duty Nursing	X		X		
Psychiatry	X			X	
Testing for Sexually Transmitted Diseases (STDs)	X		X	X (from public providers only – post authorization required)	
Transportation	X			X	
Visual	X			X	
X-Ray	X		X		

Provider Service Network – Summary of Services			
Type of Service	Covered by PSN	Not Covered by PSN	Self-Referral Required
Advanced Registered Nurse Practitioner	X		
Aged/Disabled Adult Services Waiver		X	
Ambulatory Surgical Centers	X		
Assisted Living for the Elderly Services Waiver		X	
Birth Center Services	X		
Channeling Services Waiver		X	
Chiropractic Services	X		X (up to 10 visits per year to in-network providers)
Community Mental Health Services		X	
County Health Department Services	X		X (in-network only)
Dental Services (Children)		X	
Denture Services (Adult)		X	
Dermatology Services	X		X (up to 5 visits per year to in-network providers)
Developmental Services Waiver		X	
Dialysis Services	X		
Durable Medical Equipment and Medical Supplies	X		
Child Health Check-Up Services	X		
Early Intervention Services		X	
Family Planning Services	X		X (in or out of network)
Federally Qualified Health Centers	X		X (in or out-of-network)

Provider Service Network – Summary of Services			
Type of Service	Covered by PSN	Not Covered by PSN	Self-Referral Required
Home Health Care Services	X		
Hospice Care Services		X	
Hospital Services - Inpatient	X		
Hospital Services - Outpatient	X		
Independent Laboratory Services	X		
ICF Services for Developmentally Disabled		X	
Model Waiver Services		X	
Licensed Midwife Services	X		
Medical Foster Care		X	
Nursing Facility Services		X	
Optometric Services	X		
Physician Services	X		
Physician Assistant Services	X		
Podiatry Services	X		X (up to 4 visits per year to in-network providers)
Portable X-ray Services	X		
Prescribed Drugs	X		
Prescribed Pediatric Extended Care Center Services		X	
Project AIDS Care Waiver Services		X	
Rural Health Clinic Services	X		
School-based Medicaid Services		X	X (in or out-of-network)
State Mental Hospital Services		X	
Supported Living Waiver Services		X	

Provider Service Network – Summary of Services			
Type of Service	Covered by PSN	Not Covered by PSN	Self-Referral Required
Targeted Case Management		X	
Therapy Services - Occupational	X		
Therapy Services - Physical	X		
Therapy Services – Respiratory	X		
Therapy Services - Speech	X		
Transplant Services – Organ and Bone Marrow (excluding Liver, Heart, and Lung Transplants)	X		
Transportation Services		X	
Visual Services	X		

Health Maintenance Organizations – Summary of Services

Note: An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service. Services provided under contract are negotiated with each contractor. However, contractors must provide, at a minimum, the services listed in this table. In addition, specific quality and benefit enhancement services are contractually required. Contractors may choose to provide additional services such as dental, transportation, and nursing facility services.

Service	State Plan Approved	1915(b)(3) Waiver Services	Capitated Reimbursement	Fee-for-Service Reimbursement	Fee-for-Service Reimbursement Impacted by the MCO
Child Health Check-Up Services	X		X	One fee-for-service claim may be submitted for each member within three months of the member's enrollment	
Community Mental Health Services (Medicaid Areas 1 and 6)	X		X		
Durable Medical Equipment	X		X		
Emergency Services	X		X (in or out-of-network – not prior authorized)		
Family Planning Services	X		X (in or out-of-network – not prior authorized)		
Freestanding Dialysis Centers	X		X		
Hearing Services	X		X		
Healthy Start Wraparound Services		X			

Health Maintenance Organizations – Summary of Services

Note: An HMO's services cannot be more restrictive than those provided under Medicaid fee-for-service. Services provided under contract are negotiated with each contractor. However, contractors must provide, at a minimum, the services listed in this table. In addition, specific quality and benefit enhancement services are contractually required. Contractors may choose to provide additional services such as dental, transportation, and nursing facility services.

Service	State Plan Approved	1915(b)(3) Waiver Services	Capitated Reimbursement	Fee-for-Service Reimbursement	Fee-for-Service Reimbursement Impacted by the MCO
Home Health Services	X		X		
Inpatient Hospital Services	X		X		
Laboratory Services	X		X		
Mental Health Targeted Case Management (Medicaid Areas 1 and 6)	X		X		
Outpatient Hospital Services	X		X		
Physician Services	X		X	One fee-for-service claim may be submitted for each member within three months of the member's enrollment for an Adult Health Screening	
Prescribed Drug Services	X		X		
Therapy Services	X		X		
Visual Services	X		X		
X-Ray Services	X		X		

CMS Capitated Network – Summary of Services					
Service	State Plan Approved	1915(b)(3) Waiver Services	Capitated Reimbursement	Fee-for-Service Reimbursement	Fee-for-Service Reimbursement Impacted by the MCO
Child Health Check-Up	X		X		
Dental	X			X	
Detoxification	X			X	
Developmental Disabilities Services–Early Intervention Services	X			X	
Durable Medical Equipment	X		X		
Emergency Services	X		X		
Family Planning Services	X		X		
Federally Qualified Health Center Services	X		X		
Home Health	X		X		
Hospice	X		X		
Inpatient Hospital - Psychiatric	X			X	
Inpatient Hospital – Other	X		X		

CMS Capitated Network – Summary of Services					
Service	State Plan Approved	1915(b)(3) Waiver Services	Capitated Reimbursement	Fee-for-Service Reimbursement	Fee-for-Service Reimbursement Impacted by the MCO
Immunizations	X		X		
Lab and x-ray	X		X		
Mental Health Services (Please specify) – Community Mental Health	X			X	
Nurse Midwife	X		X		
Nurse Practitioner	X		X		
Nursing Facility	X			X	
Obstetrical Services	X		X		
Occupational Therapy	X		X		
Other Psychiatric Practitioner	X			X	
Outpatient Hospital - All Other	X		X		
Outpatient Hospital - Lab & X-ray	X		X		
Personal Care	X		W9628- Full Day Prescribed Pediatric Extended Care (PPEC) W9627-1/2 Day PPEC W9613-Home Health Aide Visit, with Skilled Nursing	W9882 - Level I Medical Foster Care (MFC) W9883 - Level II MFC W9884 - Level III MFC	

CMS Capitated Network – Summary of Services					
Service	State Plan Approved	1915(b)(3) Waiver Services	Capitated Reimbursement	Fee-for-Service Reimbursement	Fee-for-Service Reimbursement Impacted by the MCO
Personal Care (continued)			W9620-Home Health Aide Visit, Without Skilled Nursing W9880-Personal Care by Home Health Aid (4 to 8 hours a day) W9629-Personal Care by Home Health Aide (9 to 24 hours a day)		
Pharmacy	X				X
Physical Therapy	X		X		
Physician Services	X		X		
Private Duty Nursing	X		X		
Professional and Clinic and Other Lab and X-ray Services	X		X		
Psychologist Services	X			X	
Rehabilitation Treatment Services	X			X	
Respiratory Care Services	X		X		
Rural Health Clinic Services	X		X		
Speech Therapy Services	X		X		

CMS Capitated Network – Summary of Services					
Service	State Plan Approved	1915(b)(3) Waiver Services	Capitated Reimbursement	Fee-for-Service Reimbursement	Fee-for-Service Reimbursement Impacted by the MCO
Substance Abuse Services	X			X	
Testing for Sexually Transmitted Diseases (STDs)	X		X		
Transportation - Emergency	X			X	
Transportation - Non-Emergency	X			X	
Vision Exams and Glasses	X		X		
Other -- Please specify	X		Transplant Services Podiatrist Chiropractor Clinic Services	Early Intervention Services Regional Perinatal Intensive Care Centers (RPICC)	

Exclusive Provider Organizations – Summary of Services					
Service	State Plan Approved	1915(b)(3) Waiver Services	Capitated Reimbursement	Fee-for-Service Reimbursement	Fee-for-Service Reimbursement Impacted by the Plan
Child Health Check-Up Services	X		X	One fee-for-service claim may be submitted for each member within three months of the member's enrollment	
Community Mental Health Services (Medicaid Area 1)	X		X		
Durable Medical Equipment	X		X		
Emergency Services	X		X (in or out-of-network – not prior authorized)		
Family Planning Services	X		X (in or out-of-network – not prior authorized)		
Freestanding Dialysis Centers	X		X		
Hearing Services	X		X		
Healthy Start Wraparound Services		X			
Home Health Services	X		X		
Inpatient Hospital Services	X		X		
Laboratory Services	X		X		

Exclusive Provider Organizations – Summary of Services					
Service	State Plan Approved	1915(b)(3) Waiver Services	Capitated Reimbursement	Fee-for-Service Reimbursement	Fee-for-Service Reimbursement Impacted by the Plan
Mental Health Targeted Case Management (Medicaid Areas 1 and 6)	X		X		
Outpatient Hospital Services	X		X		
Physician Services	X		X	One fee-for-service claim may be submitted for each member within three months of the member's enrollment for an Adult Health Screening	
Prescribed Drug Services	X		X		
Therapy Services	X		X		
Visual Services	X		X		
X-Ray Services	X		X		

Emergency Services

All enrollees have access to emergency services without prior authorization. HMOs, the PSN, the Capitated CMS Network, and EPOs are contractually required to provide open access to emergency services.

Emergency services are defined as follows:

Emergency care is defined as a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Serious jeopardy to the health of a patient, including a pregnant woman or a fetus.
2. Serious impairment of bodily functions.
3. Serious dysfunction of any bodily organ or part.

With respect to a pregnant woman:

1. That there is inadequate time to effect safe transfer to another hospital prior to delivery.
2. That a transfer may pose a threat to the health and safety of the patient or fetus.
3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

Emergency services and care means medical screening, examinations, and evaluation by a physician or to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital.

Authorization of emergency medical services by the recipient's primary provider is unnecessary. But the provider of emergency care must make a reasonable attempt to notify the enrollee's primary care physician of the existence of the emergency medical condition. If the PCP is not known, or has not been contacted, the hospital must:

1. Notify the primary care provider as soon as possible prior to discharge of the enrollee from the emergency care area; or
2. Notify the primary care provider within 24 hours or on the next business day after admission of the enrollee as an inpatient to the hospital.

The State takes the following required steps to ensure access to emergency services.

- The State ensures enrollee access to emergency services by providing adequate information to all enrollees regarding emergency service access (see Section G. Enrollee Information and Rights)

- The State ensures enrollee access to emergency services by reimbursing for the following:

  - The screening/evaluation and all medically necessary emergency services when an enrollee is referred by the assigned PCP to the emergency room, regardless of whether the prudent layperson definition was met,

  - The screening/evaluation, when an absence of clinical emergency is determined, but the enrollee's presenting symptoms met the prudent layperson definition,

  - Both the screening/evaluation and stabilization services when a clinical emergency is determined,

  - Continued emergency services until the enrollee can be safely discharged or transferred,

  - Post-stabilization services which are pre-authorized by the primary care provider, or were not pre-authorized, but the primary care provider failed to respond to a request for pre-authorization within one hour, or could not be contacted (Medicare+Choice guideline). Post-stabilization services remain covered until the primary care provider contacts the emergency room and assumes responsibility.

Family Planning Services

In accordance with 42 CFR 431.51(b), preauthorization by the enrollee's primary care provider for family planning services is prohibited under this waiver authority. Enrollees are informed of their access to family planning services in the individual program/plan brochures.

FQHC Services

Federally Qualified Health Center (FQHC) services are made available to managed care enrollees. The recipient has the right to choose an FQHC as a PCP, or choose a managed care option that has arrangements with an FQHC. If the beneficiary elects not to select a provider that would give him or her access to FQHC services, no FQHC services are required to be furnished to the beneficiary while the beneficiary is enrolled with the provider he or she selected.

Child Health Check-Up Services

The State coordinates and monitors child health check-up services under the managed care programs as follows:

- The State collects child health check-up data from primary care providers through claims or from each HMO or EPO. Ongoing medical record reviews ensure that appropriate child health check-up screens are performed.

- Immunizations and child health check-up screens are covered. On an annual basis, the State provides screening rates to CMS through the HCFA 416 report. The population enrolled in all of the Medicaid managed care programs are included in those rates.

- Primary care providers are required to provide or manage services such that children will receive vaccinations in accordance with the immunization schedule issued by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices of the U.S. Public Health Service and/or the Academy of Family Physicians.

- Primary care providers are required to provide or manage immunization services in accordance with the current Recommended Childhood Immunization Schedule that was developed and endorsed by the Advisory Committee on Immunization Practices, the Committee on Infectious Diseases of the American Academy of Pediatrics, and Infectious Diseases of the American Academy of Family Physicians.

- The Medicaid patient's parent or guardian is informed by the Agency through its fiscal agent, of screenings due in accordance with the periodicity schedule.

- MediPass providers are required to attempt to contact the parent or guardian of all new MediPass patients under 21 years of age at least twice if necessary within 3 months of their enrollment date, to perform a health risk assessment. In addition, they are also required to attempt to contact, up to twice if necessary, any patient who is more than two months behind in the periodic screening schedule.

- The MediPass PCP is required to determine if the patient is receiving treatment of supports from another agency or organization, and to obtain authorization to seek further information from the service provider to determine the possibility of inconsistencies or the need to coordinate care. Coordination is required for persons on medications for behavioral issues or for whom a behavioral program has been prescribed for serious problems. Coordination is also required for persons with physical handicaps or those with developmental disabilities or serious mental health problems.

- MediPass providers are responsible for referring eligible patients to the area Medicaid office for needed transportation assistance and for referral to a dental provider.

- HMO, EPO and PSN primary care providers are contractually required to provide child health check-up services.

Section B: Access and Capacity

Programs included under this waiver authority serve to improve a beneficiary's access to quality medical services and assure an adequate amount of services during reasonable time periods and within reasonable geographic distance from the residences of the enrolled individuals. Furthermore, access to emergency and family planning services are not restricted.

I. Access Standards

a. Availability Standards: The State has established maximum distance and travel time requirements, given recipients normal means of transportation, for enrollees' access to providers. Primary care providers and hospital services must be available within 30 minutes typical travel time, and specialty physicians and ancillary services must be within 60 minutes typical travel time from the enrollee's residence. Recipients enrolled in MediPass, the CMS Network (existing PCCM model), and the Healthy Start Coordinated Care System may receive specialty/ancillary services from any Medicaid participating provider; therefore, distance and travel time to obtain specialty services for this population is not further or longer than traditional Medicaid FFS.

Recruitment of additional providers is performed as needed to ensure adequate access for the enrolled population. Managed care plans and the Provider Service Network are contractually required to ensure adequate access to care and availability of providers within the networks. Medicaid area office staff recruit specialists as MediPass PCPs to meet the needs of the MediPass population. In addition, non-English speaking providers are recruited as needed.

b. Appointment Scheduling: The State has established standards for appointment scheduling for enrollees' access to primary care providers. Appointments for well care visits must be scheduled with the assigned PCP within one month. Urgent care must be scheduled within one day; and routine sick patient care within one week. Enrollees' must have access to health care services on a 24-hour, seven-day-a-week basis.

II. Access and Availability Monitoring

Distance and travel time requirements, in addition to standards for appointment scheduling and 24-hour access are monitored on an ongoing basis by local Medicaid staff for the MediPass PCCM Program, and through regular contractual monitoring of other managed care programs. These standards, in addition to in-office waiting times, are also monitored for Medicaid HMOs through the Consumer Assessment of Health Plans Survey

(CAHPS). Use of this monitoring tool has recently been expanded to include all managed care programs.

The State ensures that access to emergency or family planning services is made available to enrollees without prior authorization. Enrollees are made aware of the availability of such services through plan brochures/handbooks. Managed care plans and the PSN are contractually required to permit enrollees to access such services from any Medicaid provider.

In addition to those described above, the State utilizes the following procedures to monitor access to health care services under this waiver authority:

- The State monitors utilization of services, including emergency room visits, on a routine basis.

- The State monitors enrollee requests for disenrollment from their assigned managed care option on a routine basis. Requests for disenrollment from the MediPass primary care provider due to access and/or other issues is also measured on a routine basis by local Medicaid staff.

- The State monitors enrollee complaints/grievances concerning access and other issues on a routine basis.

- The State monitors enrollee access to providers using Geomapping on a periodic basis.

- The State monitors enrollee access to specialists on a periodic basis.

- The State monitors the disparities affecting ethnic and racial minorities in accessing care on a periodic basis.

III. Capacity Standards

Primary care providers may receive assignments of Medicaid recipients through MediPass, the CMS Network, the Healthy Start Coordinated Care System for Pregnant Women and Infants, the Provider Service Network, or through contracting with one or more HMOs or EPOs.

The State has set enrollment limits for primary care providers. An upper limit of 1,500 Medicaid enrollees per physician, plus 750 enrollees per full time equivalent Advanced Registered Nurse Practioner (ARNP) or Physician Assistant (PA), as required by Florida Statute, is established for all managed care options, with the exception of the Healthy Start Coordinated Care System (see next

section). In addition, a primary care physician's total caseload of active patients may not exceed 3,000. Active patients are defined as patients who have been seen by the primary care physician at least three times per year.

The PSN, HMOs, and EPOs are contractually required to ensure an adequate geographic distribution of both primary care and specialty providers. The provider network for each of the managed care programs is routinely reported to the State to ensure contractual compliance.

Provider recruitment is an on-going activity for the MediPass PCCM program. In addition to recruiting new providers as needed, existing MediPass providers are contacted to increase maximum enrollment quotas when appropriate. The State ensures adequate geographic distribution of MediPass primary care providers by focusing recruitment efforts in areas that have few providers and a large number of Medicaid recipients. To increase the availability of MediPass PCPs, the State permits ARNPs to enroll as MediPass primary care providers with an enrollment cap of 750 recipients in Bay, Marion and Escambia Counties. ARNPs in these areas are eligible to receive both voluntary and mandatory assignments. In all other MediPass counties and for all other managed care options, primary care providers are permitted to use ARNPs and PAs to expand their patient limit by 750 for each full time equivalent ARNP and PA practicing with them. In addition, ARNPs and PAs can also enroll as MediPass primary care providers and receive voluntary enrollments. Each full time equivalent ARNP or PA may not see more than 750 recipients regardless of the number of locations in which they practice.

The chart below illustrates the number of providers currently participating as MediPass primary care providers throughout the State.

Provider Specialty	Number of Primary Care Providers
1. Pediatricians	800
2. Family Practitioners	757
3. Internal Medicine	729
4. General Practitioners	431
5. OB/GYN	93
6. Public Health Providers	220
7. ARNPs and Certified Nurse Midwives	4
8. Other Specialty Providers	56

The average primary care provider/beneficiary ratio for MediPass is currently 1:143 (statewide). The current average ratio for each MediPass area is provided in the chart below.

Area	Average PCP-to-Beneficiary Ratio
Area 1	1:168
Area 2	1:178
Area 3	1:210
Area 4	1:168
Area 5	1:114
Area 6	1:123
Area 7	1:136
Area 8	1:165
Area 9	1:197
Area 10	1:91
Area 11	1:118

Healthy Start Coordinated Care System for Pregnant Women and Infants

Primary care providers who participate in this program are not allowed to care for more than 150 pregnant Medicaid recipients per full time equivalent practitioner practicing with the provider. This ratio is consistent with current data on the number of deliveries per OB/GYN in the state. If a provider is over the limit, they are ineligible for mandatory assignments.

Providers who are not physicians are limited to a caseload of 75 enrollees. Physicians with extenders can increase their caseload by 75 per full-time extender. Extenders include qualified midwives, ARNPs, residents, fellows and Physician Assistants.

IV. Capacity Monitoring

The State requires that a primary care physician's total patient caseload does not exceed 3,000 active patients. The PSN, HMOs, and EPOs are contractually

required to monitor this requirement. MediPass PCPs are required to sign an attestation to their MediPass provider agreement, which states that the total active patient caseload does not exceed 3,000 patients per PCP.

The following methods are used by the State to monitor provider capacity:

- Routine monthly provider capacity / provider network report
- Routine tracking of disenrollments from managed care plans, including but not limited to requests due to capacity issues
- Routine tracking of complaints/grievances, including but not limited to those concerning capacity issues
- Periodic review of adequate capacity relative to the demographics of the population in each geographic area
- Ongoing review of termination rates of MediPass primary care providers, including reasons for terminations
- Ongoing review of MediPass enrollee requests for disenrollment from a MediPass primary care provider, including but not limited to requests due to capacity issues

V. Continuity and Coordination of Care Standards

The State requires the following procedures to ensure continuity and coordination of care:

- Each enrollee selects or is assigned to a designated health care practitioner who is primarily responsible for coordinating the enrollee's overall health care. The assigned PCP maintains the overall responsibility for the health care of recipients. This includes providing primary care services to assigned recipients; making referrals for specialty care when medically necessary and appropriate; following the results of the referrals; maintaining a comprehensive medical record which documents the continuum of care provided; and adhering to established quality-of-care standards.
- Each provider maintains each enrollee’s health records that meet the requirements established by the State, taking into account professional standards.

- Case management / continuity of care for all Medicaid recipients enrolled in managed care is required and is the responsibility of the assigned managed care program. Specific minimum functions are contractually required for the PSN, HMOs and EPOs. The assigned PCP for MediPass enrollees is responsible for providing case management to MediPass enrollees. CMS Network enrollees receive additional case management services through Children's Medical Services, the State's Title V provider. MediPass recipients, who are not enrolled in the CMS Network and who have a chronic and disabling condition for which a disease management program is available, will receive case management for their condition through the appropriate disease management program. Recipients who are enrolled in the Healthy Start Coordinated Care System receive case management through the local Healthy Start Coalitions.

- Additional care coordination standards are contractually required to address the needs of specific special populations with developmental and/or behavioral disabilities that may be enrolled in a managed care program.

The State requires that the primary care provider coordinate and/or facilitate the provision of health care services with the following providers:

- Mental Health Providers
- Substance Abuse Providers
- Dental Providers
- Transportation Providers
- Home and Community-Based Services (HCBS) Waiver (1915c) Service Providers
- Developmental Disabilities Providers
- Title V Providers
- Women, Infants and Children (WIC) Program
- Disease Management Programs (MediPass Providers Only)

VI. Continuity and Coordination of Care Monitoring

State Medicaid staff monitor continuity and coordination of care for MediPass enrolled physicians through ongoing medical record reviews. Each month

Medicaid headquarters staff select, on a random basis, a sample of MediPass physicians and a sample of their assigned recipients. Local Medicaid nurses are provided with this sample of providers and recipients each month. The nurses perform detailed medical record reviews, using a standard review tool, and submit findings to headquarters on a monthly basis. Additional reviews are also performed by local Medicaid staff during the credentialing and recredentialing process.

The State contractually requires that the PSN, HMOs and EPOs maintain written case management and continuity of care protocols. Protocols include processes for coordinating with other systems of care to provide comprehensive services for enrollees, including those with special needs. State Medicaid staff monitor these requirements on a routine basis.

Section C. Quality of Care and Services

Programs included under this waiver authority serve to improve a beneficiary's access to quality medical services by assuring an adequate amount of services during reasonable time periods and within reasonable geographic distance from the residences of the enrolled recipients. Furthermore, access to emergency and family planning services are not restricted.

If a problem is identified regarding access to care or the quality of services received, the State may intervene as indicated below:

- Provide education and informal mailings to recipients and primary care providers;
- Initiate telephone and/or mail inquiries and follow-up;
- Request primary care provider’s response to identified problems;
- Refer to program staff for further investigation;
- Send warning letters to primary care providers;
- Refer to State's medical staff for investigation;
- Institute corrective action plans and follow-up;
- Change a beneficiary's primary care provider;
- Institute a restriction on the types of recipients;
- Further limit the number of assignments;
- Ban new assignments;
- Transfer some or all assignments to different primary care providers;
- Suspend or terminate primary care providers; or
- Suspend or terminate as Medicaid providers.

I. Monitoring Quality of Services The State monitors access to and quality of services using a variety of approaches including record reviews, surveys, data analysis, and coordination with other State Agencies.

The State contracts with an independent Peer Review Organization to monitor the quality of services being provided to Medicaid enrollees. The State's Peer Review Organization has conducted numerous medical record audits focused on seven areas regarding the technical quality and content of the medical records, baseline data, patient visits, continuity of care, consultations, ancillary services and chronic disease follow-up. PRO reviews have been conducted for MediPass and HMO managed care programs. The last PRO, FMQAI, conducted medical record reviews between January 1, 1998 through June 30, 1998. During this time period the PRO completed reviews for 594 MediPass cases and 2,947 HMO cases.

The State has a contract with a Peer Review Organization, KEPRO, to perform random medical record reviews for Medicaid recipients who received services through one of Medicaid's managed care programs. Reviews are scheduled to begin after July 1, 2002.

In addition to the medical record reviews performed by State Medicaid staff and through the independent PRO, periodic enrollee experience surveys (which includes questions concerning the enrollees access to and quality of services) are mailed to a sample of enrollees including persons with special needs. Such surveys are conducted through CAHPS and various independent evaluations. Patient satisfaction and assessment surveys are conducted by each disease management organization for those MediPass recipients enrolled in a particular disease management program. Special needs children enrolled in the CMS Network are also surveyed by Children's Medical Services on an annual basis. Corrective actions are taken on deficiencies found as appropriate.

The Agency produces an annual report on Medicaid outcome measures. The most recent report, dated September 2001, provides findings for 54 measures during FY 1999-00. Findings from this report indicate that the State improved on 22 of the measures from FY 1998-99. Medicaid outcome measures have been reviewed on an annual basis by the State over the past five years. The Agency has and continues to make substantial progress on the number of its Medicaid-related indicators.

In addition to the annual report described above, the Agency produces a periodic report to compare the performance of available Medicaid managed care programs on selected HEDIS measures. The report produced by the Agency in February 2001 provides a comparison on eight HEDIS performance measures. This report found that HMOs tend to do as well or better than MediPass on the items measured.

Focused quality of care reviews are conducted by the State on a periodic basis. The following quality improvement projects were conducted for the State by the last Peer Review Organization: Apnea monitor utilization, hospital ER non-

physician screening criteria, diabetes management, asthma management, and epilepsy management. In addition to the quality improvement projects conducted by the PRO, focused studies are conducted by each disease management organization to evaluate the quality and appropriateness of care provided to MediPass recipients enrolled in a disease management program. These studies are conducted at the State/PCCM level in addition to the provider level. Clinical areas assessed in these studies focus on the extent to which specific protocols, treatment guidelines, and clinical pathways of the targeted disease state are being followed.

Managed Care Program-Specific Quality of Care Monitoring

MediPass

In addition to the general managed care monitoring approaches described above, MediPass program operations are monitored on a routine basis throughout the State by both local Medicaid staff and headquarters staff.

The MediPass Utilization Review System (MURS) provides data which is used to evaluate the performance of participating MediPass providers and the MediPass program. The system stratifies data according to the major groups of MediPass participating providers: general/family practice, obstetrics/gynecology, internal medicine, pediatrics, publicly funded health care providers, ARNP/PA, and specialists. Service utilization rates for nine service categories are calculated for each MediPass provider, participating specialty group, and all MediPass providers combined. On a monthly basis, the paid authorized claims for every MediPass provider are calculated, by each service category, to identify areas that may indicate quality of care issues. Over-utilization is considered to be 95% or greater, as determined by evaluation of all providers statewide within a provider grouping. Under-utilization is considered to be 5% or less, as determined by evaluating all providers statewide within a provider grouping. For MediPass providers with over-utilization rates, detailed claims data pertaining to services received by their MediPass enrollees is generated.

The MURS reports are distributed to MediPass providers on a monthly basis to allow them to compare their MediPass caseload utilization to those of other MediPass providers. MediPass staff also review the utilization reports to monitor individual MediPass provider utilization patterns. Additional analysis is conducted for providers which are identified as an over-utilizer or under-utilizer for any service category.

CMS Network:

Under Florida law, the Department of Health, Children's Medical Services (CMS) Program Office, has the responsibility for administering services under Title V of

the Social Security Act. CMS is responsible for ensuring that all providers of service are eligible for participation in the Medicaid program and meet standards as set forth in the CMS Network contract. In addition, current CMS Network providers are also included in the same monitoring as MediPass providers. The current MediPass utilization review system (MURS), described above, is used to track the performance of CMS Network providers.

Healthy Start:

At a minimum, Healthy Start services are monitored based on criteria outlined in the Healthy Start Standards and Guidelines. All contracts and memoranda of agreement with service providers include provisions regarding the quality assurance and improvement process to be followed. DOH is responsible for ensuring that the Coalitions monitor their providers, and will intervene if any subcontracts or memorandum of agreement are not in compliance with law, regulation, or program policies.

All providers of Healthy Start services are required to have an internal quality improvement/quality assurance plan in place. This plan must be reported to the Coalitions at the beginning of the contract. Providers are required to routinely assess program strengths and to identify areas for program improvement. Providers regularly report to the Coalitions findings from their own internal quality improvement process.

All providers of Healthy Start services will also have performance measures outlined in their contracts/memoranda of agreement. The Coalitions and each service provider jointly determine these measures. Contracts and memoranda of agreement specify that service provision is in accordance with statewide standards outlined in the Healthy Start Standards and Guidelines document.

Monitoring activities of the Healthy Start provider contracts or memoranda of agreement include a review of service provision, performance measures, client satisfaction, and client outcomes. This review will be accomplished through the review of quarterly programmatic and financial reports, annual site visits, and annual chart reviews. Chart audits will be done annually on a sample of at least 20 to 30 stratified provider records. Monitoring will focus on contract compliance, compliance with the Healthy Start Standards and Guidelines, quality of service provision, and progress in meeting performance measures.

Provider Service Network:

The Provider Service Network is contractually required to develop internal management reports to monitor clinical, access and administrative performance. Periodic surveys of the PSN are conducted to determine compliance with contract requirements. The State has also established specific qualitative

measures to assess the quality of health care provided to Medicaid recipients enrolled in the PSN. The percentage of the shared savings pool available to the PSN is determined by their performance on the qualitative measures, as identified in the contract.

Medicaid HMOs:

Medicaid HMOs are contractually required to monitor clinical, access and administrative performance. The agency has implemented a comprehensive plan for the ongoing monitoring of quality of care in the HMOs. Specific monitoring activities to ensure contractual compliance include an initial survey, annual surveys, and quarterly HMO targeted monitoring. The Agency also collects and analyzes data, submitted by each HMO, on plan finances, utilization, disenrollments, grievances, patient satisfaction, and Child Health Check-Up compliance. This information is used as ongoing indicators of plan performance which identify the focus for the quarterly targeted monitoring, validation surveys, and special investigations.

EPOs:

Medicaid EPOs will be contractually required to monitor clinical, access and administrative performance. The agency will implement a comprehensive plan for the ongoing monitoring of quality of care in the EPOs.

II. Selection and Retention of Providers The State has implemented specific processes and procedures for selecting and retaining primary care providers who are eligible to participate in managed care programs included under this waiver authority.

MediPass / CMS Network (PCCM model)

The State has the following processes in place to select and retain primary care providers for the MediPass program and for the current CMS Network:

- Has a documented process for selection and retention of primary care providers which includes an initial credentialing process for primary care providers that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

- Has a recredentialing process for primary care providers that is accomplished within the time frame set by the State and through a process that updates information obtained through the following:
  - ✓ Initial credentialing

- ✓ Performance measures, including those obtained through MURS and the complaint and appeals system.

- Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.

- Has an initial and recredentialing process for primary care providers other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

- Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of primary care providers take place because of quality deficiencies.

In addition to the above processes, CMS Network providers must be licensed and qualified to perform necessary services for children with special health care needs. The Department of Health, Children's Medical Services (CMS) Program Office is responsible for written policies and procedures for monitoring providers and for sanctioning providers who are out of compliance with the approved medical management standards.

CMS Network (Capitated Model)

It is anticipated that CMS credentialed providers who have traditionally treated children with special needs will enroll in the capitated CMS Network to continue treating this population. All providers within the capitated network must be licensed and qualified to perform necessary services for this patient population, and will be credentialed by the Integrated Care System (ICS). The Department of Health must ensure that biannual recredentialing of all providers in the care system is conducted to document each provider's continued adherence to requirements.

Healthy Start Coordinated Care System

A panel of obstetrical care providers to serve recipients in the Healthy Start Coordinated Care System for Pregnant Women and Infants program will be developed and credentialed by the Agency with input from the statewide advisory group. Providers will be selected from those enrolled in the Medicaid program who agree to meet standards of care and/or have demonstrated performance of care.

Provider Service Network, HMOs and EPOs

The PSN, HMOs, and EPOs are responsible for credentialing and recredentialing their provider networks in accordance with the credentialing requirements as outlined in each contract. In addition, all PSN primary care providers must be Medicaid providers and meet all MediPass provider requirements. A primary care provider may not simultaneously participate in MediPass and a PSN, unless the provider is enrolled in MediPass as a CMS Network provider.

III. Health Information Systems

The State has the following health information systems in place to collect, analyze, integrate, and report data to enable the Agency to achieve the objectives of the Medicaid Program.

- Florida Medicaid Management Information System (FMMIS)
- Computer Output Laser Disk System (COLD)
  - ✓ Management and Administrative Reporting Subsystem (MARS)
  - ✓ Medicaid Utilization Review Subsystem (MURS)
- Florida Medicaid Data Warehouse
  - ✓ Five years of Medicaid claims history
  - ✓ Provider, recipient and reference tables
  - ✓ Executive Information System
  - ✓ User friendly ad-hoc query tools
  - ✓ Statistical and data mining capabilities
  - ✓ Incorporates AdvanceMed clinical methodologies
  - ✓ OmniAlert component enhances Medicaid fraud and abuse detection
- Florida Regulatory and Administrative Enforcement System (FRAES)
  - ✓ Database used to house, track and retrieve MediPass provider network activities
  - ✓ Used to track and trigger credentialing process for MediPass providers
- Benova's Beneficiary Enrollment Services Software and Technology System (BESST)
  - ✓ Database used to process recipient enrollment, disenrollment, and managed care plan changes
  - ✓ Database used to record and report all choice counseling phone contacts
- Teletrack
  - ✓ Database used to log all area office telephone activities

The State also uses other state data sources, such as birth records, hospital discharge files, and the immunization registry, to monitor care provided to Medicaid managed care enrollees. The State uses provider files and recipient eligibility files to match Medicaid recipients and providers to these other data sources:

- ✓ Department of Health Vital Statistics
- ✓ Department of Health Immunization Registry
- ✓ Department of Elder Affairs
- ✓ Hospital Discharge Data
- ✓ National Practioner Data Bank
- ✓ CoreSTAT Data Bank

Section D. Fraud and Abuse

The State takes the following measures to promote the prevention, detection, and reporting of fraud and abuse in managed care programs:

I. State Payment Mechanism Controls

- The State has systems to avoid paying for unauthorized services (e.g., denial of claims for services which must have the referral of the primary care provider).

- The State has in place a formal plan for preventing, detecting, pursuing, and reporting fraud and abuse in Medicaid.

- The State operates a Medicaid Fraud and Abuse Hotline and refers each report to the appropriate authority to further investigate and/or take action.

- When a MediPass provider is being investigated for fraud or abuse by Medicaid or Medicare, the provider's enrollments may be limited to current enrollees or the provider may be terminated from the MediPass program until the investigation is complete.

II. Primary Care Provider Provision

- Medicaid providers are contractually required to cooperate with State and/or Federal investigations.

Section E. Special Populations

I. General Provisions for Special Populations

The Department of Health, Division of Children's Medical Services (CMS) is the State of Florida's Title V Agency responsible for the provision of services for children with special health care needs. Children medically eligible for Children's Medical Services who receive Medicaid benefits are served through the Children's Medical Services Network. The balance of children identified with special needs are served by the State's Title V agency through the Children's Medical Services Network. However, these children may elect to participate in any other Medicaid managed care program available in their geographic location. Children with special health care needs who are enrolled in Medicaid managed care plans and who may benefit from the Children's Medical Services Network are referred for enrollment.

The BBA enumerated four federal programs and a Medicaid optional coverage category that are likely to include individuals under age 19 with disabilities or chronic conditions. Children who fall under one of these categories are referred to as having "special needs". The categories, and the managed care options available to Florida Medicaid children within each category, are as follows:

- *Supplemental Security Income (SSI) under the Social Security Act:* Children who fall under this category are enrolled in MediPass, the CMS Network, the PSN or in a Medicaid HMO or EPO. These children may disenroll and re-enroll into another EPO, HMO, MediPass, or the Provider Service Network for any cause and at any time. These children may also enroll into the CMS Network if medically eligible.

- *The Model Waiver state plan option*: Children who fall under this category are included under the state's Model Waiver; therefore, this population is not enrolled in any managed care program described in this document.

- *Maternal and Child Health Services Block Grant for children with special health care needs under Title V of the Social Security Act*: Recipients who fall under this category are served by the State's Title V Agency through the Children's Medical Services Network (CMS Network). These children are identified through a medical eligibility screening tool. Therefore, CMS Network eligible children are not limited to specific eligibility codes. CMS Network enrollees represent all codes, including SSI and TANF-related. Although this population is eligible to enroll and receive services through the CMS Network, they may voluntarily choose to enroll in any other managed care option.

- *Federal adoption assistance or foster care programs under title IV-E of the*

Social Security Act and foster care or out-of-home placements funded from other sources: Children in protective custody, foster care and subsidized adoption are mandatorily enrolled into the State's Primary Care Case Management Program (MediPass), unless the Children and Families (C&F) worker enrolls the child into another managed care option. C&F staff may determine that a special needs child would be better served in an HMO, e.g., the child's provider is a member of that HMO only. To carry out this enrollment, the C&F worker simply contacts the agency's third party choice counselor and requests the enrollment. Proof of the C&F worker's authority to request the enrollment must be faxed to the choice counselor. If the child is voluntarily enrolled into an HMO, the plan must receive written authorization from (1) a parent if the parental rights have not been terminated or (2) the Department of Children and Families if the parental rights have been terminated. If a parent is unavailable, the plan must obtain authorization from the Department of Children and Families.

To accommodate the special needs of foster children, MediPass staff allow C&F staff to make the initial recommendation for the provider selection. C&F staff and/or foster parents may change doctors for children in foster care at any time and for any reason simply by calling the local MediPass Office. MediPass staff will assign children in subsidized adoption arrangements to providers based on geographical location. Parents have the same options and time frames for changing providers for their adoptive children as children in foster care.

MediPass staff meet periodically with C&F staff to assist any new staff with understanding the MediPass program since it is critical that C&F staff know what to do when they have a MediPass recipient in their custody. By law, every child entering emergency shelter care must obtain an initial health care assessment by a licensed health care provider, using EPSDT procedures, within 72 hours after placement in shelter care. If a child placed in shelter care needs medical attention for a condition that is not an emergency, the shelter parents are advised to call the child's assigned MediPass provider. The MediPass provider may authorize the child to be seen by the Medicaid provider the shelter parents normally use.

Florida Medicaid provides services to each of the above subsets of children. MediPass, the CMS Network, the Healthy Start Coordinated Care System, the Provider Service Network (PSN), and the HMOs and EPOs provide all services outlined in the State Medicaid Plan and addressed in the various Florida Medicaid handbooks and waivers as referenced in specific Florida Administrative Code rules. Both FMMIS and CMS data systems maintain data on these children. In addition to the assistance categories with modifiers (ACWMs) used to identify children with special needs, FMMIS has other types of codes that can track services, provider types, provider/waiver specialty types, location of

services, etc. CMS also maintains a separate data system that tracks all enrollees, for case management and other data collection reasons in compliance with Title V and SSA requirements, and Florida statutes.

The Florida Medicaid Management Information System (FMMIS) is designed to capture all of the above subsets of children with special needs with Assistance Category codes (ACWMs). All Medicaid recipients, including the above subset of recipients, are assigned ACWMs whether the individuals voluntarily make a choice or are assigned a provider by the State's choice counseling contractor. Whether the provider assignment is voluntary or mandatory, and whether the child establishes a provider relationship with a MediPass, Healthy Start, PSN, HMO, EPO, or waiver provider, CMS identifies recipient children with special medical needs.

The State manages the balance of medically eligible children with special needs through the Department of Health (DOH), Division of Children's Medical Services (CMS). This DOH division is charged with the responsibility of managing and coordinating services provided to medically eligible Title V funded children, blind and disabled children (Title XVI, SSI eligibles), and children eligible through the Model Waiver formerly known as the Katie Becket program. Children's Medical Services holds the responsibility for maintaining data on these children with special medical needs. CMS, through interagency agreements with the Agency (Medicaid), is required to collect and maintain specific data on all children with special needs enrolled in their network. Children with special health care needs who are enrolled in Medicaid managed care plans and who may benefit from the Children's Medical Services Network are referred for enrollment.

The State's choice counseling contractor, Benova, may also identify children with special health care needs. Screening questions are asked by Benova counselors to determine if the child who is eligible for managed care has a special health care need. If special health care needs are identified or suspected, the necessary information to contact Children's Medical Services for further information and for medical eligibility screening is provided.

Children's Medical Services has a statutorily mandated Advisory Council composed of 12 members representing the private health care provider sector, families with children who have special health care needs, the Agency for Health Care Administration, the Department of Insurance, the Florida Chapter of the American Academy of Pediatrics, an academic health center pediatric program, and the health insurance industry. Specific duties of the Council include, but are not limited to the following:

- Recommending standards and credentialing requirements of health care providers rendering health services to Children's Medical Services network participants.

- Making recommendations to the Director of the Division of Children's Medical Services concerning the selection of health care providers for the Children's Medical Services Network.

- Reviewing and making recommendations concerning network health care provider or participant disputes that are brought to the attention of the advisory council.

- Providing input to the Children's Medical Services program on the policies governing the Children's Medical Services Network.

- Reviewing the financial reports and financial status of the network and making recommendations concerning the methods of payment and cost controls for the network.

- Reviewing and recommending the scope of benefits for the network.

- Reviewing network performance measures and outcomes and making recommendations for improvements to the network and its maintenance and collection of data and information.

In addition, the Agency's Bureau of Managed Care sponsors an Advocacy and Consumer Workgroup on a periodic basis to provide an opportunity for participation from relevant parties. This workgroup is comprised of various advocates, providers and consumer groups including representatives from the following organizations: the Advocacy Center for Persons with Disabilities, Florida Legal Services, the Developmental Disabilities Council, the Center for Prevention and Early Intervention Policy, the Statewide Human Rights Advocacy Committee, the Florida Alcohol and Drug Abuse Association, the Florida Council for Community Mental Health, the Children's Home Society, the Florida Psychiatric Society, the Department of Children and Families, and the Department of Health.

All children currently enrolled in the CMS Network are assigned a nurse case manager who is responsible for providing both primary and specialty care case management, ensuring continuity of care, linkages with community resources and coordination of the flow of information between the PCP, CMS, supporting programs and the family.

Medicaid HMOs are contractually required to complete certain medical studies to ensure quality of care for specific medical conditions. Additionally, staff interview the HMO case management staff to ensure that the policies and procedures are being followed and implemented. Agency staff examines their peer review process and reviews the committee minutes.

The Department of Health, Division of Children's Medical Services, is the state entity charged with the responsibility of determining performance measures for medically eligible children with special health care needs. CMS has developed measures that comply with the requirements of Title V and Florida Statutes that address issues with children with special needs. The Division of CMS designs projects that address issues with these children and Florida Medicaid works cooperatively with CMS through various waivers and with unique CMS guidelines to provide services to children with special needs.

The following Title V measures are reported by Children's Medical Services on a statewide basis:

- The percentage of Part C eligible children receiving services.

- The percent of SSI recipients less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs program.

- The degree to which the State Children with Special Health Care Needs Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its recipients.

- The percent of Children with Special Health Care Needs in the State who have a "medical/health home".

- Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).

- Percentage of newborns who have been screened for hearing impairments before hospital discharge.

- Percent of children with special health care needs in the State Children with Special Health Care Needs program with a source of insurance for primary and specialty care.

- The degree to which the State assures family participation in program and policy activities in the State Children with Special Health Care Needs program.

The State also utilizes the CAHPS survey tool to monitor the Medicaid managed care population, including the special needs subpopulation. The population surveyed includes children under age five and over age five who are enrolled in an HMO, in MediPass, or in the CMS Network. Both parent and youth surveys

are conducted as appropriate. The following areas are monitored through this tool:

- Access to services
- Quality of care
- Coordination of care

II. State Mechanisms for Providers

Current CMS enrollees receive primary and specialty care through the existing CMS network. All CMS primary and specialty care providers must meet both Medicaid and CMS credentialing requirements. CMS Network providers who serve as PCPs are required to meet the following standards, in addition to MediPass standards, to provide services to children enrolled in the CMS Network:

1. Must have hospital admitting privileges at a CMS designated hospital.

2. Must be Board Certified or Board Admissible and obtain board certification within two exam cycles.

3. Must be a member in good standing with the local medical society or professional organization.

4. Must have two letters of recommendation from physicians in their specialty area.

5. Must receive a recommendation from the CMS Assistant Secretary.

6. Must be reapproved every three years.

The State has provisions which allow MediPass and CMS Network recipients who utilize specialists frequently for their health care to be allowed to maintain these types of specialists as primary care providers. Under the current PCCM model children enrolled in MediPass or the CMS Network may receive specialty services from any Medicaid provider. Furthermore, many PCPs are specialists, thereby allowing children with special needs who utilize specialists frequently to maintain those providers as PCPs.

If a specialist makes himself available to the HMO network as a PCP, then a member may choose that specialist as a PCP. The State conducts annual reviews of the HMOs' network capacity as well as monitoring all complaints for lack of access to specialists. Agency staff use a monitoring instrument to monitor network capacity. Staff monitor the network directory of current plans annually,

through desk review, random telephonic interviews, and random on-site reviews.

As part of its criteria for contracting with primary care providers, the State assesses skill and experience level in accommodating people with special needs as appropriate. The HMOs, EPOs, and the PSN are contractually required to ensure that there are sufficient experienced providers to serve all enrolled members, including those children who have special needs.

The State contractually requires the PSN, HMOs and EPOs to have the following specialists available, on at least a referral basis: allergist; cardiologist; endocrinologist; general surgeon; obstetrical/gynecology (OB/GYN); neurologist; nephrologist; orthopedist; urologist; dermatologist; otolaryngologist; pulmonologist; chiropractic physician; podiatrist; ophthalmologist; optometrist; neurosurgeon; gastroenterologist; oncologist; radiologist; pathologist; anesthesiologist; psychiatrist; oral surgeon; physical, respiratory, speech and occupational therapists; and a specialist in AIDS care or an infectious disease specialist. Community mental health providers and targeted case management providers are included in the HMO provider network in Area 1 (Escambia, Okaloosa, Santa Rosa and Walton counties) and in Area 6 (Hardee, Highlands, Polk, Manatee, and Hillsborough counties); behavioral health services are not a mandated benefit in the rest of the state.

The PSN is required to make available specialists with pediatric expertise for children where the need for pediatric specialty care is significantly different from the need for adult specialists. The PSN, EPOs, and the HMOs are required to have specialists available for referral. If a needed specialist is not in the PSN or the HMO's network, they would be required to obtain the services of a specialist in the area of that specialty as needed.

The State collects population-specific data for special populations. Number of complaints, grievances, and voluntary disenrollments are collected for special needs children who receive services through a Medicaid HMO or through the CMS Network. In the past, this information has been provided to the Centers for Medicare and Medicaid Services.

Section F. Complaints, Grievances, and Fair Hearings

All Medicaid enrollees have access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

- informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action;

- ensuring that enrollees may request continuation of benefits during a course of treatment and during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with state policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued or reinstated; and

- other requirements for fair hearings found in Subpart E.

In addition, complaint and grievance procedures are administered by the State to provide for prompt resolution of issues for those recipients enrolled in MediPass, the PSN, the CMS Network, an HMO, or an EPO. Complaint/grievance decisions may be appealed to the Agency. In addition, the complainant retains the right to pursue a Medicaid fair hearing at any time by contacting the Department of Children and Families.

MediPass and CMS Network recipients are advised in the recipient handbook to contact a MediPass counselor if they have a problem with any aspect of MediPass. Local CMS offices coordinate with the Medicaid office to resolve complaints/grievances from CMS Network recipients. Recipients enrolled in the Healthy Start Coordinated Care System are advised, in the program's brochure, to contact the Healthy Start office to register any complaint or grievance. Documentation is kept for each complaint and grievance registered. When three or more complaints are registered against a MediPass provider or a recipient, an in-depth review is conducted. On-site visits may be necessary to investigate repeated grievances or complaints. A provider may be terminated from MediPass if he or she fails to resolve a validated operational complaint within 30 days. A local registered nurse specialist or physician consultant investigates quality of medical care complaints, and may refer such complaints to peer review committees within the Florida Medical Association or the Florida Osteopathic Medical Association. A MediPass provider who fails to resolve a validated quality of medical care complaint within 30 days is terminated from MediPass.

The Provider Service Network, HMOs and EPOs are contractually required to develop and implement complaint/grievance and expedited grievance procedures. The PSN, HMOs and EPOs are monitored by the agency to insure that complaints and grievances are handled appropriately and efficiently. The Agency also maintains a toll free call center that refers callers to appropriate points of contact in an attempt to resolve emergency, urgent, or routine complaints from both HMO subscribers and providers. If

warranted, the Agency conducts on-site investigations to resolve complaints, identify problems, and make recommendations on any actions or penalties to be imposed. To the extent that complaint investigations indicate a serious deficiency in the plan, a complete survey of the plan may also be conducted to review the plan's overall performance and compliance with quality of care standards. Complaints involving poor or substandard care delivered by a licensed health care provider are referred to the Agency's Division of Medical Quality Assurance for appropriate action. Callers may also be referred to ombudsmen councils for possible resolutions.

In addition, disease management organizations are also contractually required to develop appropriate guidelines that address recipients' complaints and avenues for resolutions.

I. Definitions

"Complaint" is defined as any expression of dissatisfaction by a subscriber, including dissatisfaction with the administration, claims practices, or provision of services, which relates to the quality of care provided by a provider pursuant to the organization's contract and which is submitted to the organization or to the Agency. A complaint is part of the informal steps of a grievance procedure and is not part of the formal steps of a grievance procedure unless it is a grievance as defined next. "Grievance" is defined as a written complaint submitted by or on behalf of a subscriber to an organization or a state agency regarding the:
availability, coverage for the delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; claims payment, handling, or reimbursement for health care services; or
matters pertaining to the contractual relationship between a subscriber and an organization.

Complaints, grievances, and associated resolutions are documented and tracked for all populations, including the special needs population. Telephone and written complaints also serve as indicators of potential and on-going problems with quality of care. In-depth investigations are conducted, as appropriate, as a result of this information.

II. State Requirements and State Monitoring Activities

Required Fair Hearings Elements:

- ✓ An enrollee can request a State fair hearing for reductions, terminations and suspensions of Medicaid covered services under the State's fair hearing process.

- ✓ Enrollees are informed about their fair hearing rights at the time of Medicaid eligibility determination and at the time of any action as defined in 42 CFR 431 Subpart E.

- ✓ The State ensures that enrollees may request continuation of benefits or reinstatement of services during a course of treatment during a fair hearing appeal. The State informs enrollees of the procedures by which benefits can be continued or reinstated.

- ✓ Recipients are also informed about their fair hearing rights at the time of PCCM enrollment through the MediPass brochure. Recipients are also informed, as appropriate, when a complaint/grievance is made.

- ✓ A recipient may appeal a plan's grievance decision to the Agency.

- ✓ Recipients always retain the right to file an administrative hearing in lieu of, or in addition to, filing a complaint or grievance.

Section G. Enrollee Information and Rights

I. Enrollee Information - Understandable to Enrollees The state ensures that information about programs included under this waiver authority is clear and understandable to enrollees and potential enrollees. Enrollment materials are written at the fourth grade level and are provided to all enrollees and potential enrollees in both English and Spanish. In addition, audio tapes are available to blind enrollees and potential enrollees. All enrollees and potential enrollees have access to a toll-free number to call for questions and additional information (TTY/TDD available). Translation services are available to all enrollees, regardless of the languages spoken.

II. Enrollee Information - Content

Information Provided by the State and/or it's Enrollment Broker. The state and/or its enrollment broker provide or coordinate the provision of the following information to enrollees and potential enrollees.

- An initial notification letter.
- Informational materials to assist individuals in choosing a managed care option.
- Informational materials describing how to appropriately access services under the managed care system and advising them of enrollees' rights and responsibilities.
- Upon request, a list of MediPass and/or CMS Network primary care providers serving the enrollee's geographical area, including information about which providers are accepting new Medicaid enrollees and any restrictions on enrollees' ability to select from among primary care providers.
- Comparative information on Medicaid managed care plans.
- Information on how to obtain telephone counseling on choice of managed care option.
- A membership card or cardholder which includes the plan's name and telephone number or the primary care provider's name and telephone number to be attached to accompany the original Medicaid card.
- Special health care needs information is obtained from potential enrollees to provide to the PSN, HMOs and EPOs; also, to enable an initial screening for CMS Network eligibility.

- Information concerning the availability of special services, expertise, and experience offered by available managed care options (programs available to assist recipients with special needs, such as the CMS Network and available disease management programs).

- Information explaining the grievance procedures and how to exercise due process rights and their fair hearing rights.

- Information about their right to disenroll without cause the first 90 days of each enrollment period. (See A.III.b)

- Information on how to obtain non-managed services that are covered under the State Plan.

- For enrollees in the lock-in period, notification 60 days prior to end of enrollment period of right to change managed care plans (See A.III.b).

- Procedures for obtaining primary care services from the primary care provider.

- Procedures for obtaining after-hours and emergency coverage, including:

    - ✓ definition of emergency services and an emergency medical condition;

    - ✓ the prohibition on retrospective denials for services that meet the prudent layperson definition (e.g., to treat what appeared to the enrollee to be an emergency medical condition at the time the enrollee presents at an emergency room); and

    - ✓ the right to access emergency services without prior authorization.

- Procedures for obtaining non-covered or out-of-area services.

- Any special conditions or charges that may apply to obtaining services.

- The right to obtain family planning services from any Medicaid-participating provider.

- Procedures for obtaining referrals for specialty care and other services requiring authorization but not furnished by the enrollee's primary care provider.

- Procedures for changing primary care providers, including the ability to change managed care plans for cause at anytime

- Procedures for obtaining mental health and substance abuse services.

- Notification of termination or changes in benefits, services, service sites, or affiliated providers. Notices are provided in a timely manner.

- Procedures for obtaining services to which an enrollee can self-refer (see Section A.III.d).

- Instructions on how to obtain information in languages other than English.

- Instructions on how to obtain translation services.

- Instructions on how to obtain information in alternative formats (e.g., for low literacy individuals or for the visually impaired).

III. Enrollee Rights The following processes and procedures are used by the state to ensure that enrollee rights are protected in the states managed care programs:

- Have written policies with respect to enrollee rights.

- Communicate policies to enrollees, staff and providers.

- Monitor and promote compliance with their policies by staff and providers.

- Ensure compliance with federal and state laws affecting the rights of enrollees such as all civil rights and anti-discrimination laws.

- Implement procedures to ensure the confidentiality of health and medical records and of other information about enrollees.

- Implement procedures to ensure that enrollees are not discriminated against in the delivery of medically necessary services.

- Ensure that all services, both clinical and non-clinical, are accessible to all enrollees, including special populations.

- Ensure that each enrollee may select his or her primary care provider from among those accepting new Medicaid enrollees.

- Ensure that each enrollee has the right to refuse care from specific providers.

- Have specific written policies and procedures that allow enrollees to have access to his or her medical records in accordance with applicable Federal and State laws.

- Comply with requirements of Federal and State law with respect to advance directives.

- Have specific written policies that allow enrollees to receive information on available treatment options or alternative courses of care, regardless of whether or not they are a covered benefit.

- Allow direct access to specialists for recipients with long-term or chronic care needs by enabling recipients to choose a specialist as the primary care provider.

IV. Monitoring Compliance with Enrollee Information and Enrollee Rights The following processes and procedures are used by the State to monitor compliance with its requirements for enrollee information and rights.

- The State tracks disenrollments and reasons for disenrollments.

- The State approves all marketing materials used by the MediPass primary care providers, the Healthy Start providers, the PSN, the HMOs, and the EPOs.

- The State monitors the primary care provider's compliance with the enrollee rights provisions through ongoing reviews/audits of providers, and through comprehensive reviews of MediPass, the CMS Network, the Healthy Start Coordinated Care Program for Pregnant Women and Children, the PSN and of each HMO and EPO.

Section H. Cost Effectiveness

(*NOTE:* Tables 1 through 9 are included in Appendix 1)

To obtain cost estimates for the population included under this waiver authority, claims data was extracted using the same program for setting capitation rates. Per member per month (PMPM) expenditures by major expenditure categories were calculated starting in State Fiscal Year 1994-1995 (the starting point for previous MediPass waiver applications) forward through FY 2000-2001 (adjusted upward by the IBNR factor). Per member per month expenditures were obtained for each of the following groups included under this waiver authority:

TANF eligible for MediPass

- Overall expenditures (PMPM fee-for-service and MediPass). This includes the population that is enrolled in MediPass, in a DM program within MediPass, in the CMS Network, or in the Provider Service Network (PSN). This excludes the population enrolled in HMOs.

- Expenditures for fee-for-service includes only case months for the MediPass-eligible population. This represents all case months, including those case months prior to enrollment into a managed care option (MediPass, the CMS Network, the PSN, or an HMO).

- Expenditures for MediPass-only case months. This includes only managed-care case months for the population that is enrolled in MediPass, in a DM program within MediPass, in the CMS Network, or in the PSN. Expenditures are also provided separately for the following groups:
  - ✓ CMS Network enrollees
  - ✓ PSN enrollees
  - ✓ Enrollees under the age of 1

- Expenditures for HMO-only case months. This includes case months and the associated capitation rates for the population that is enrolled in an HMO.

SSI eligible for MediPass

- Overall expenditures (PMPM fee-for-service and MediPass). This includes the population that is enrolled in MediPass, in a DM program within MediPass, in the CMS Network, or in the Provider Service Network (PSN). This excludes the population enrolled in HMOs.

- Expenditures for fee-for-service includes only case months for the MediPass-eligible population. This represents all case months, including those case months prior to enrollment into a managed care option (MediPass, the CMS Network, the PSN, or an HMO).

- Expenditures for MediPass-only case months. This includes only managed-care case months for the population that is enrolled in MediPass, in a DM program within MediPass, in the CMS Network, or in the PSN. Expenditures are also provided separately for the following groups:
  - ✓ CMS Network enrollees
  - ✓ PSN enrollees
  - ✓ Enrollees under the age of 1

- Expenditures for HMO-only case months. This includes case months and the associated capitation rates for the population that is enrolled in an HMO.

SOBRA Pregnant Women (which was only fee for service during the time period covered). A table representing total costs by expenditure category is provided for this population.

Compound trends were calculated for each of the eligibility groups and are presented in Table 1. To determine costs without the waiver, the difference between the compound trend for the fee-for-service group and for the MediPass group was applied to the overall costs found for MediPass-eligible recipients for the historical assessment. The overall compound trend was used to project future expenditures. Since the SOBRA pregnant women program was not operational during the historical assessment, the compound trend for SOBRA pregnant woman expenditures was applied to the future projections. The historical assessment from the previous waiver authority and projections of the future are in Table 2.

The methodology differs from that used in the prior waiver submission for the two look-back years. In the previous submission, it was projected that future costs would continue to rise at the average rate of medical inflation for both fee-for-service and MediPass. Unfortunately this was not the case. For example, pharmacy costs rose dramatically. Even though growth in pharmacy rates per member per month was stable in FY 2000-2001, the huge increase from the prior year remained while other costs continued to increase more than expected. See Tables 4 through 8 for details by expenditure category for current PCCM waiver programs included under this waiver authority.

MediPass seems to have alleviated the effect of the other cost increases in that cost increases for MediPass were substantially less than fee-for-service costs of those eligible for MediPass. See trend data presented earlier in Table 1. Prior to FY 1999-2000 fee-for-service and MediPass rates increased at approximately the same rate.

During the last two years rate increases were substantially higher for MediPass eligibles not yet enrolled in managed care. Thus, to determine the rate of costs without the waiver programs, the difference in the compound trend was used for the look-back. Cost savings for years prior to the look-back were not revised from the previous submission.

HMO Costs (See Table 9)

Health Maintenance Organization (HMO) capitation rates are based on historical fee-for-service expenditures for the entire Medicaid population (including the MediPass population), adjusted forward to the contract period. Children with special needs who may be enrolled in an HMO are accounted for in this methodology to the extent that they are served through Medicaid and not enrolled in the state's Children's Medical Services Network (CMS Network).

Health Maintenance Organization (HMO) costs without the PCCM waiver would be higher as the rates are built off the combined fee-for-service and MediPass rates. It is assumed that without the waiver costs would be higher by the percentage saved by MediPass. In calculating the HMO rates, MediPass savings from two years prior to the year under consideration are used. The reason is due to the fact that HMO rates are built off of historical claims from two years prior, adjusted for expected increases. Thus, to the extent that MediPass saved money in those prior years, savings are reflected in the future HMO rate. These savings in HMO rates have not been included in the demonstration of cost savings for MediPass.

Table 9 illustrates the PMPM and aggregate costs for the population enrolled in the HMO option. These reported rates cannot be compared directly to the reported per member per month costs in MediPass for the following reasons:

- MediPass includes a large number of counties in which there is not an HMO. Costs in the counties may differ from the areas with HMOs.

- HMO rates are based on historical claims data from both fee-for-service and MediPass claims, excluding CMS Network enrollees, from two years prior. These figures are then projected forward at the same price and utilization increases projected for the MediPass and fee-for-service population. Rates are set by eligibility category, age, gender and county.

- The profile of HMO enrollees differs from those served through the PCCM programs. Age and gender need to be controlled in any comparison. In addition to age and gender, other significant differences are present. Examples of these differences are as follows:

- Those recipients who have a chronic illness, such as HIV/AIDS often elect to remain fee-for-service through enrolling in MediPass.

- The balance of high cost special needs children are served through the CMS Network. Children who are case managed by CMS are not enrolled in an HMO unless they disenroll from the CMS Network and select an HMO. The CMS Network is Florida's Title V program. The network is valuable to special needs children and their parents, as there are additional quality standards in place. In addition, some specialty physicians limit their patient caseload to CMS Network enrollees. The same network is used for the SCHIP program and those not eligible for either program, thus if children switch eligibility categories their care remains uninterrupted.

- Infants are less likely to be enrolled in an HMO since the majority of infants are born to SOBRA eligible mothers who are predominately served under fee for service. Most of these infants are eligible for Medicaid for 12 months as a result of continuous eligibility provisions. Since they are not enrolled in an HMO at birth, they would be served fee-for-service while going through the enrollment process. If a medical problem is present, the infant would be enrolled in the CMS Network. Infants cost more than other groups to serve.

- African Americans and Hispanics are disproportionately enrolled in HMOs. These groups, especially Hispanics, tend to utilize services less frequently.

EPO costs

Exclusive Provider Organization (EPO) capitation rates will be based on historical fee-for-service expenditures for the Medicaid population (including the MediPass population), adjusted forward to the contract period. Rates will not exceed per-member-per-month (PMPM) expenditures for the Medicaid fee-for-service population (historical FFS expenditures and projections are detailed in Table 4). No anticipated cost savings have been incorporated into this cost effectiveness demonstration.

Case months without the waiver

Actual case months for Medicaid eligibles and SOBRA pregnant women not enrolled in an HMO were used for the look-back estimates. This includes fee-for-service prior to enrollment in managed care, as well as case months in MediPass. Future projections were determined assuming that the number of case months would remain the same as for FY 2000-2001. Data was abstracted from the Florida Medicaid Management Information System (FMMIS).

Table A

Case Months for MediPass Eligibles and the SOBRA Pregnant Women Program (not enrolled in an HMO)

Fiscal Year	TANF Case Months	SSI Case Months	SOBRA Case Months
1994-95	8,623,087	2,031,837	529,888
1995-96	8,219,686	2,149,861	513,684
1996-97	7,623,258	2,187,554	531,527
1997-98	6,955,775	2,217,487	495,377
1998-99	6,572,403	2,073,933	478,705
1999-00	7,140,191	2,086,652	484,417
2000-01	8,109,223	2,140,733	541,498
2001-02	8,109,223	2,140,733	541,498
2002-03	8,109,223	2,140,733	541,498

Case Months with Waiver

Case months with the waiver are the same as for without the waiver for SSI, TANF and SOBRA pregnant women, estimates are actual caseloads from FY 2000-2001. It was decided to use the last year's case months so as to standardize comparisons. There may be changes as a result of the auto-assignment process and the economy. These should not have an effect on the per-member-per-month costs, only the total dollars.

The number of Healthy Start women, infants and young children served who are Medicaid eligible is expected to grow from the current rate served by Healthy Start. The enrollment targets for each year of the programs are presented in Table B. All of these women and children would have been eligible for Medicaid under existing Medicaid and Healthy Start guidelines, but were not reached due to funding restrictions in the program prior to inclusion under Medicaid.

Case months for disease management programs and the PSN are also actual months for the historical assessment. PSN caseloads were projected to remain the same as the prior year (Table C). The projected DM caseloads are provided in Table D, and reflect proposed contract renewals.

Table B
Healthy Start Coordinated Care System
Projected Case Months

Program	Fiscal Year 2001-02	Fiscal Year 2002-03
SOBRA Choice Counseling/Management	406,345	541,793
Healthy Start Wrap Around		
Pregnant Women at Risk	35,764	39,340
Infants at Risk	93,178	100,000
1-3 Year Olds at Risk	50,664	66,496

Table C
Provider Service Network
Member Months

Eligibility Group	Fiscal Year 1999-00	Fiscal Year 2000-01	Fiscal Year 2001-02	Fiscal Year 2002-03
TANF	32,169	196,240	196,240	196,240
SSI	10,099	59,366	59,366	59,366

Costs under the waiver

First, per member per month costs under the waiver were projected forward to obtain actual costs for Medicaid eligibles in FY 2000-2001 (the IBNR adjustment was applied to the FY 2000-01 data) using the overall compound trend calculated from the historical data. The same factor was used to project costs forward without the waiver. This approach includes the current effects of disease management initiatives and the Provider Service Network. Thus, the increased savings that are expected to occur with continued participation or development of these programs are not included. Therefore, the cost savings of these programs could be understated in the projections, since most have performance guarantees and are also expected to produce long-range savings for the enrolled population. It also does not take into account any additional savings from other value added programs that will be implemented by the State. In addition, the State also uses this waiver authority to test innovative pilot projects, such as the Diabetes Pharmacy Mail Order Program. These pilot projects, implemented in specific limited geographic areas of the State, are expected to further reduce expenditures.

Projected enrollment levels and associated costs for disease management programs are presented in Table D based on proposed contracts for next year. The rate of reimbursement is also provided. Agency reconciliation tables for each DM program may be provided to CMS when available. Total and PMPM expenditures for the

population served through DM programs are included in Tables 2 through 4 (overall costs for SSI and TANF PCCM recipients).

PSN costs by expenditure category are reported in Table 6. Total costs for the population served through the PSN were also included in the PCCM summary data (Tables 2 through 4) which reveals associated cost savings. Administrative costs are based on paid amounts and are assumed to remain constant, as the caseload was assumed to remain constant. First year findings for the PSN initiative resulted in the PSN having some cost savings. The amount to be given to the PSN for the first year reflects amounts paid based on first year data, even though reconciliation occurred in FY 2000-01. Reconciliation has not occurred for the subsequent year, but expenditures are budgeted as if the rate for the first four months would be found in future months. By contract, the PSN can retain a position of savings achieved.

The administrative and other program costs necessary for operating the Provider Service Network, the disease management (DM) programs and the Healthy Start program are not included as per member per month costs. These costs are reported in the Table 2 historical assessment as additional costs. The DM costs have been adjusted to reflect the projected caseload that will remain enrolled in current programs.

Table D:
Disease Management
Administrative Fees Paid

		FY 1999-2000		FY 2000-2001		FY 2001-2002	
DMO	**PMPM**	**Enrollees**	**Total Cost**	**Enrollees**	**Total Cost**	**Projected Enrollees**	**Projected Total Cost**
HIV/AIDS							
AIDS Healthcare Foundation	$90	2,211	$2,387,750	3,749	$4,048,485	3,400	$3,672,000
Hemophilia							
Accordant	$100	53	$63,000	57	$67,500	N/A	N/A
Caremark	$75	27	$24,300	40	$35,325	120	$108,000
Congestive Heart Failure							
LifeMasters	$125	N/A	N/A	2,129	$3,193,000	3,000	$4,500,000
End Stage Renal Disease							
Renal Management Services	$155	N/A	N/A	3,118	$5,798,240	4,000	$7,440,000
Diabetes							
Coordinated Care Systems	$43	17,208	$8,879,197	13,671	$7,053,979	4,500	$2,322,000
Chronic Obstructive Pulmonary Disease							
Cybercare	N/A	N/A	N/A	25	$82,275	N/A	N/A

Since the Healthy Start Program was not operational in FY 2000-01, costs with the waiver were reduced only for future costs. Savings realized through this program are reflected in reduced costs for serving the pregnant women, and in first year infant costs. Historical first year infant costs, with and without the Healthy Start program, are reported in Table 7 by expenditure category. These costs are also included in the TANF and SSI population data in Table 2, in addition to the overall PCCM costs reported in Tables 3 and 4. Although costs and savings for the infant population is reported separately, only the effects of the program are added to the look-back assessment in Table 2, as the costs and savings for this population are already included in the overall TANF and SSI population data. These additional savings projected as a result of this program are in addition to any MediPass savings reflected previously.

Savings from the Healthy Start program were determined as follows:

SOBRA Pregnant Women

1. The cost of hospital services was reduced to reflect fewer complicated deliveries. The average cost per day in the hospital, in fiscal year 2000-01, is $830.44. Savings assume that there would be a reduction of one hospital day for 10 percent of current complicated deliveries. Since the actual number of complicated deliveries in 1999 is 39,340, savings are estimated for 3,934 of these deliveries (10 percent of current complicated deliveries). Total projected savings would be $3,266,950 (3,934 deliveries times the average daily hospital cost of $830.44). Only half of the savings were included for the first year of this project, as half of those served during the first year will not deliver until the second year. In addition, some of the women delivering in the first year would not have been exposed to the program for an adequate amount of time to significantly impact outcomes. This estimate will underestimate savings to the extent that hospital per-diem rates increase.

2. Physician costs are also decreased to reflect a 10 percent decline in the number of complicated deliveries. Florida pays physicians $300 more per complicated delivery. Assuming that complicated deliveries are reduced by 3,934 deliveries, an annual savings of $1,180,280 would be realized for overall physician costs (3,934 deliveries times $300 physician fee). Savings are projected to be only half of this in the first year of program operations, as some of the women would not receive the full benefit of services until the last half of the first year.

Reduced Costs to Infants

Reduced health costs to infants are expected for the following reasons:

- Children will have better birth outcomes. This will reduce the percentage of infants served by Medicaid who are SSI eligible in the first year of life, in addition

to reducing the cost of inpatient hospitalizations, outpatient hospitalizations and other services used by infants in both the TANF and SSI programs.

- The Healthy Start program provides services to at risk infants that should result in fewer ambulatory sensitive hospitalizations. Therefore, reductions are reflected in inpatient, emergency room, and outpatient costs. The need for 'other' services are also expected to decrease. No reductions in remaining costs are indicated.

The number of SSI case months is expected to decrease from current rates by 176 case months in the second year. Benefits are not anticipated to begin until the second half of the first year, therefore only 88 case months are estimated to decrease in year one. This equates to about 8 or 9 babies in the first year and 19–20 babies in the second year. Savings are estimated by obtaining the difference between the TANF related rate and the SSI rate for serving babies, which results in a $2,750.19 savings in the first year, and $3,139.02 savings in the second year. Thus, program savings, in addition to reductions in the PMPM, is estimated at $242,017 in year one and $552,468 in year two. This will be reflected in growth in case months rather than a reduction in real numbers, as caseloads are expected to grow as Healthy Start will ensure that babies are enrolled more promptly in Medicaid at birth. Although all born to SOBRA women are eligible for 12 months post birth, some are not currently obtaining coverage by failure to register a social security number. Except for this projected savings, savings assume the current level of caseloads. Since levels are expected to increase, savings will likely be higher than those projected.

In estimating other infant savings under the waiver, it was projected that inpatient hospital costs would decrease by 10 percent, outpatient hospital costs by 5 percent, and other costs by 5 percent. Most savings would be achieved in the first year with the expansion of Healthy Start services to at risk infants who were born to women delivering prior to their receipt of the expanded services.

Savings are also underestimated in that costs of reduced medical needs for older children are not included. Healthy Start can serve at risk children up to age 3 and hopefully reduce their need for hospital inpatient and emergency room care for conditions that could have been prevented. Effects of the program on children served will be examined in the evaluation.

Waiver Costs not Included in Per Member Per Month Costs

The savings in medical costs presented in the historical data are prior to inclusion of any administrative or program costs. To achieve overall savings these program and administrative costs must be added in. Table D provides projected disease management costs which are included as additional waiver costs in Table 2. PSN administrative costs are also included as an additional cost in Table 2. Additional costs

projected for the Healthy Start program (Table E) were also included in Table 2. Projected costs for the Healthy Start program were determined as follows:

Medicaid will participate in the costs of services to eligible recipients, and will provide the federal match for general revenue expenditures made by the coalitions. Federal participation is limited to its share of the following:

- For each pregnant at risk women served by Healthy Start, Medicaid will reimburse the Department of Health (DOH), which administers the Healthy Start Program, the federal share of a global fee of $ 556.89. Only one fee will be available in a twelve-month period for the eligible women. The Department of Health must certify expenditure of the state match position of the global fee. The fee is only paid for eligible women at risk. Services provided vary by need.

- In addition, a $12 monthly fee will be paid for each SOBRA recipient. This fee is intended to cover the cost of assisting women in choosing a provider and managing the care of the pregnant women to ensure that needed medical services are received. Three dollars of this fee is the equivalent of the MediPass case management fee. Similar services are provided to pregnant women eligible through MediPass by that program. The remaining is considered the administrative cost of choice counseling services provided through the Healthy Start program, and is reimbursed at the administrative rate. The DOH must certify that the state share of the remaining $9 is met.

- For each at risk child born who is eligible for Medicaid, federal participation will be provided at a monthly fee of $52.73 for each child under 1, and $28.51 for each child served who is age 1 to 3 during the month.

Estimates of Healthy Start program costs by recipient enrollment category is provided in Table E.

Table E
Healthy Start Program
Projected Caseload and Expenditures

Service	Fee	Caseload Fiscal Year 2001-02	Projected Expenditures Fiscal Year 2001-02	Caseload Fiscal Year 2002-03	Projected Expenditures Fiscal Year 2002-03
SOBRA-oversight	$12 per month	406,345	$4,876,140	541,793	$ 6,501,516
Healthy Start prenatal	$556.89 per year per at risk woman served	35,764*	$19,916,614	39,340*	$21.908,053
At risk Infants under 1	$52.73 per month served	93,178	$4,913,276	100,000	$45,273,000
At risk children Age 1-3	$28.51 per month served	50,664	$1,444,431	66,496	$1,895,801
Total expenditure			*$31,150,461*		*$35,577,570*

* Number of pregnant women

Cost Effectiveness Summary

As illustrated in Table 2, a five percent savings is projected in FY 2001-02 and 2002-03 for implementation of PCCM program components included under this waiver authority. This overall savings includes the Healthy Start Coordinated Care System for Pregnant Women and Infants in addition to the MediPass PCCM program, which includes the CMS Network, the Provider Service Network, and various disease management initiatives. A 3 percent and 4 percent savings were realized in prior years (FY 1999-2000 and FY 2000-01). Increased savings are expected due to implementation of new programs, including the Healthy Start Coordinated Care System, the Diabetes Mail Order Program, and other value added initiatives. Furthermore, additional savings are expected over the next two years from the improved health status of the chronically ill population as a result of increased care management provided through the current and past disease management programs.

Health Maintenance Organization (HMO) costs are detailed in Table 9. HMO rates are built off of the combined fee-for-service and MediPass historical claims from two years prior, therefore savings from the PCCM programs are reflected in the HMO rates.

Actual costs for the population served through an HMO are provided, in addition to what costs would be for this same population enrolled in an HMO without including MediPass claims in the calculation of the HMO rates. As illustrated in this table, HMO rates are reduced from savings obtained through the MediPass program. For example, the average capitation rate for an SSI recipient enrolled in an HMO in FY 1999-00 was $414.34. This rate would have been $453.81 if MediPass historical claims were not considered in setting HMO capitation rates. These savings in HMO rates have not been included as cost savings in Table 2.

Tables 3 through 8 illustrate actual and projected expenditures by program category. Table 3 provides an overall comparison of PCCM and FFS costs by eligibility category. Table 4 illustrates PCCM waiver costs by eligibility and expenditure category. Costs are reported for all casemonths (PCCM and FFS) for the eligible population, in addition to casemonths in which the population is enrolled in a PCCM program (PCCM program includes MediPass, the PSN, and the CMS Network). For example, in FY 1999-2000, the overall PMPM (PCCM and FFS casemonths) for an eligible TANF recipient is $139.06, whereas the overall PMPM (PCCM casemonths only) for an enrolled TANF recipient is $116.22. Separate costs are also reported for these populations excluding the CMS Network population. For example, in FY 1999-2000, the average PMPM for an enrolled TANF recipient who is not served through the CMS Network is $108.23. Table 5 illustrates costs, by eligibility and expenditure category, for the CMS Network population. In FY 1999-2000, the average PMPM for an enrolled TANF recipient who is served through the CMS Network is $409.23.

Table 6 illustrates costs, also by eligibility and expenditure category, for the population served through the Provider Service Network. The population included in this table is also included in Tables 3 and 4.

Table 7 illustrates costs by eligibility and expenditure category for infants (under age 1). This population is also included in the overall costs for the PCCM programs (Tables 3 through 6). Reported costs indicate that infant costs are significantly higher than costs for other age groups served. Projected savings from implementation of the Healthy Start program are included in this table.

Table 8 illustrates costs by eligibility and expenditure category for SOBRA pregnant women. This population is not included in the preceding tables, as this population is not eligible for other managed care programs. Projected savings from implementation of the Healthy Start program are included in this table. These savings are included in Table 2 to obtain overall savings. Total savings from implementation of the Healthy Start program component to serve this population is projected to be $2,223,615 for year 1 (FY 2001-02) and $6,789,142 for year 2 of the program (FY 2002-03).

Additional administrative costs for programs are detailed in Tables D and E. These additional costs, in addition to costs associated with the Provider Service Network, are included in Table 2. Total savings from implementation of programs included under this

waiver authority are reduced by these administrative and program implementation costs to obtain an overall savings of $159,619,556 (5 percent) in FY 2001-02 and $173,491,936 (5 percent) in FY 2002-03.